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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02396 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02383

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY in 1b MINUTES d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 100 BLOCK N. JONATHAN STREET				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND f. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 122 ROSS STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CARL Middle NMN Last AKOWSKY				4. DATE OF DEATH Month FEBRUARY Day 23 Year 1962			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 13 1896	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) METAL SORTER		10b. KIND OF BUSINESS OR INDUSTRY SALVAGE COMPANY		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-0717		17. INFORMANT CARL F AKOWSKY Address 3800 81st AVENUE WASHINGTON D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) 4-20-1 DUE TO Obstruction of Coronary Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ascending Branch Left Coronary Artery (c) Coronary Arteriosclerosis Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20. INTERVAL BETWEEN ONSET AND DEATH Instant 21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE A. E. W. Ditto Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E.W. DITTO JR. M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-26-62			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2-27-62		22c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S CEMETERY	
23. FUNERAL DIRECTOR SUTER-ROUZER FUNERAL HOME				ADDRESS HAGERSTOWN MD		22d. LOCATION (City, town, or country) (State) WILSON DISTRICT MARYLAND	
24a. REC'D BY REGISTRAR MAR 1 '62				24b. REGISTRAR'S SIGNATURE William S. Finner			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02384

02397

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland d. STREET ADDRESS 104 Fairview Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Motten Last Allen				4. DATE OF DEATH Month 2 Day 22 Year 19 62			
5. SEX F		6. COLOR OR RACE B		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1.14.1874	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 2 Days 22		IF UNDER 24 HRS. Hours 19 Min. 62			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hancock Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Not Known				14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Burman Allen Hancock Md.		Address	
18. CAUSE OF DEATH (Enter only one cause and line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ch. Myocarditis DUE TO Ch. nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. similarity DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 10 Wks 11							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 21 1962 to Feb 22 62 , that (I) just last saw the deceased alive on Feb 21 19 62 and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE L.M. Shaffer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) L.M. SHAFER	
22d. ADDRESS Hancock Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2.24.62		23c. NAME OF CEMETERY OR CREMATORIUM Riverview		23d. LOCATION (City, town or county) (State) Hancock Washington Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hancock & Stone Hancock Md				25a. REC'D BY REGISTRAR FEB 27 '62		25b. REGISTRAR'S SIGNATURE Charles L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

Ch. Proprietor
Ch. Registrar
Ch. Secretary

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN life LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 224 S. MULBERRY ST.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 226 S. MULBERRY ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY ALBERTA ANDREWS		4. DATE OF DEATH FEBRUARY 23 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/3/1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM BOWERS	
14. MOTHER'S MAIDEN NAME IDA McCALL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. C. FRANK ANDREWS Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary thrombosis 4-25-60 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 5 minutes Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis; Cholelithiasis			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White Not White of work at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-7-1957 , 19....., to death , 19....., that (I) (we) last saw the deceased alive on 2-12-62 , 19....., and that death occurred at 4:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Paul Harrison M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 2-24-62	
22c. PHYSICIAN'S NAME (Type or print) Robert F. Keadle		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/26/62	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Hornum ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE FEB 27 '62	
25b. REGISTRAR'S SIGNATURE Charles E. Hume			

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Company (Incorporated)
Attest: Secretary

Company (Incorporated); President

2-13-77

1977, 2-13

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02399 CERTIFICATE OF DEATH 02387

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Pinesburg		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Pinesburg	
c. LENGTH OF STAY IN 1b 50 yrs.		d. STREET ADDRESS Williamsport RFD #1 Md.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Williamsport RFD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Katherine Banzhoff		4. DATE OF DEATH Month Day Year Feb. 20 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22 1874
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 5 28	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME George Unger		14. MOTHER'S MAIDEN NAME Elizabeth Burger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Pinesburg #1 Mr. Keller Banzhoff Williamsport Md RFD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) DUE TO c)		AC. Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/20/62 to 2/20/62, that (I) (we) last saw the deceased alive on 2/20/62, and that death occurred on 2/20/62, from the causes and on the date stated above.			
22a. SIGNATURE Ralph F. Young		22b. ADDRESS WILLIAMSPORT, MARYLAND	
22c. PHYSICIAN'S NAME (Type) RALPH F. YOUNG		22d. ADDRESS WILLIAMSPORT, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 23-62	
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town or county) (State) Williamsport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Loef Williamsport, Md		25a. REC'D BY REGISTRAR DATE FEB 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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Item 8 Film G308 2/28/62 iwr

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 2 Weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 514 North Mulberry Street		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 514 North Mulberry Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edgar Middle N. M. N. Last BENNETT		4. DATE OF DEATH Month Feb. Day 21 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889 May 3, 1887 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yard Conductor W.M. RR Retired		10b. KIND OF BUSINESS OR INDUSTRY Summit Point Berkley Co	
11. BIRTHPLACE (County & State, or Foreign Country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Bennett		14. MOTHER'S MAIDEN NAME Ella Pope	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-5292	
17. INFORMANT Donald Bennett		Address 1948 W. Washington st Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Myocardial Infarct 420.0 DUE TO Chr Conjestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 5 min months yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m. none	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) - (County) - (State) -
21. I certify that (I) (this hospital) attended the deceased from Aug. 1961 to Feb 21 , 1962, that (I) (was) last saw the deceased alive on Feb. 21 , 1962, and that death occurred at 7:00 P. M, from the causes and on the date stated above.			
22a. SIGNATURE Harold R. Tritch Jr M.D.		22b. DATE SIGNED 2-22-62	
22c. PHYSICIAN'S NAME (Type) Harold R. Tritch, Jr. M.D		22d. ADDRESS 302 N. Potomac Street- Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/24/62	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.		25a. REC'D BY REGISTRAR FEB 26 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

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CERTIFICATE OF DEATH

Reg. Dist. No. 02389

1. PLACE OF DEATH a. COUNTY Washington County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Berkeley			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium				d. STREET ADDRESS 512 West Martin Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Meveral Clagett Blondel				4. DATE OF DEATH Month February Day 23 Year 1962			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1872 December 1962	
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Interwoven Stocking Company		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Anthony Blondel				14. MOTHER'S MAIDEN NAME Clara Huber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Mary C. Blondel, 512 W. Martin Street				Address Martinsburg, W.V.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 334X DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs plus (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertrophy of the prostate							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1945 to Feb. 23, 1962 , that I last saw the deceased alive on Feb. 13, 1962 , and that death occurred at 1:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter H. Shealy				ADDRESS (Street, city or town, state) Sharpsburg Maryland			
DATE SIGNED 2/24/62							
PHYSICIAN'S NAME (Type) Dr. Walter H. Shealy							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 23 Feb. 1962		22c. NAME OF CEMETERY OR CREMATORY Rosedale cemetery		22d. LOCATION (City, town, or county) (State) Martinsburg, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter H. Shealy				ADDRESS Sharpsburg Maryland		24a. REC'D BY REGISTRAR DATE FEB 26 '62	
				24b. REGISTRAR'S SIGNATURE Carroll S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

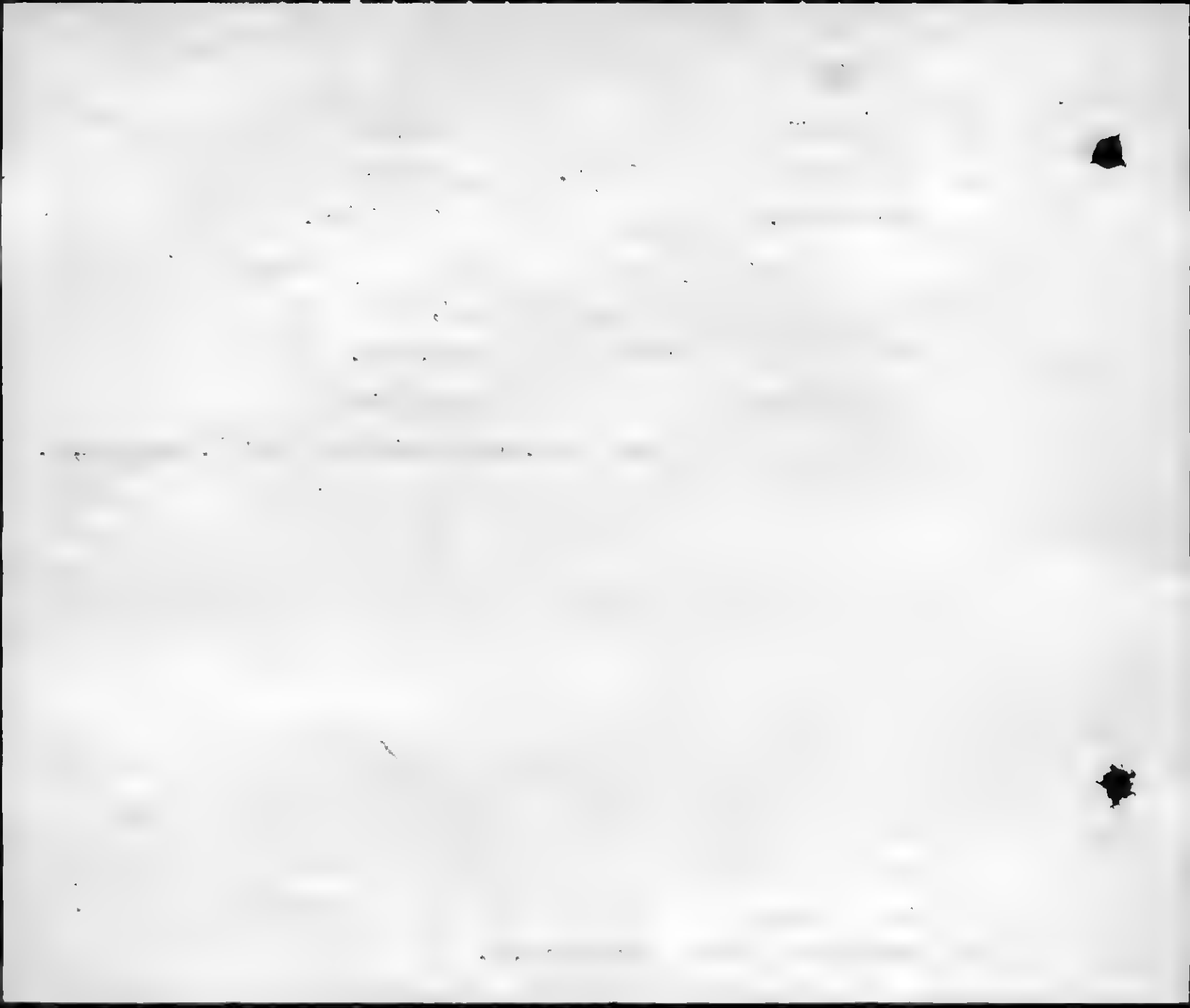
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02402

02350

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>219 Mill St.</u>		d. STREET ADDRESS <u>219 Mill St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Estella Mary Bond</u>		4. DATE OF DEATH Month Day Year <u>February 3 19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 1, 1897</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Marion, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Kiser</u>		14. MOTHER'S MAIDEN NAME <u>Florence Deitrich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Howard Rudisill</u>		Address <u>221 Mill St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>720.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Coronary Thrombosis</u> <u>Extensive Myocardial Infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-1-62</u> to <u>2-3-62</u> , that (I) (we) last saw the deceased alive on <u>3-1-62</u> , and that death occurred on <u>2-3-62</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. E. W. LITTO</u>		22b. DATE SIGNED <u>2/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. E. W. LITTO</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/6/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Harst</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>William G. Harst</u>			

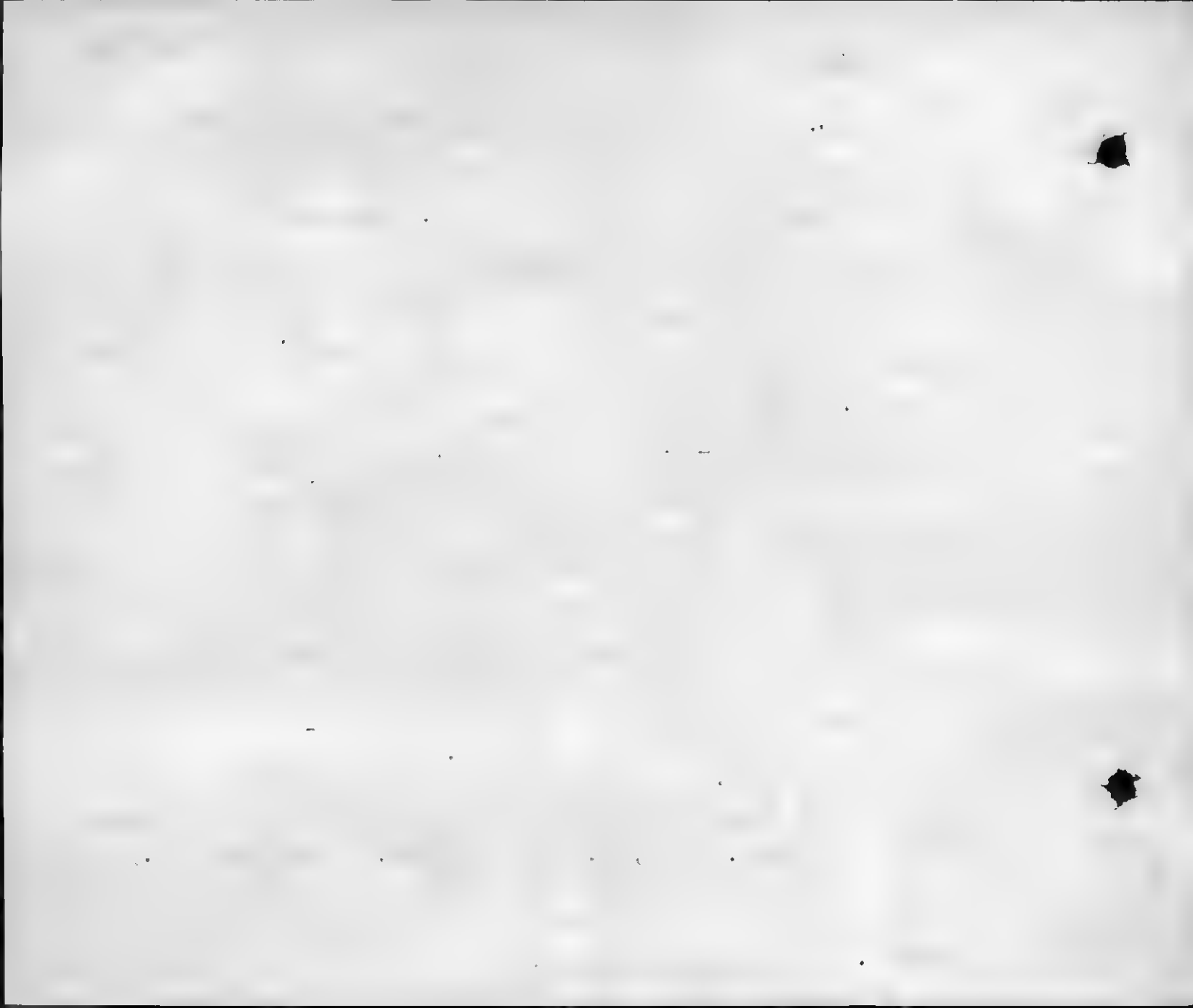


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
022403 CERTIFICATE OF DEATH 023391											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b. <u>2 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>436 W. Washington St</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EARL</u> <u>LEALAND</u> <u>BREWER</u>				4. DATE OF DEATH <u>Feb</u> <u>17</u> <u>1962</u>				5. AGE (In years, last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
6. COLOR OR RACE <u>White</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/>				8. DATE OF BIRTH <u>Nov 24 1882</u>			
9. SEX <u>Male</u>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Id.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Jacob A. Brewer</u>			
14. MOTHER'S MAIDEN NAME <u>Carrie Eyerly</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>219-20-2108</u>			
17. INFORMANT <u>Le Roy E. Brewer</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). <u>Arteriosclerotic heart disease with failure</u> DUE TO <u>Bundle branch block</u> DUE TO <u>generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>yrs</u> <u>yrs</u> <u>yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Advanced senility</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>				20c. TIME OF INJURY Month, Day, Year <u>None</u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> <u>None</u>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>				20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1961</u> to <u>Feb. 17, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17, 1962</u> , and that death occurred at <u> </u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold R. Tritch, Jr.</u>				22b. DATE SIGNED <u>2-19-62</u>				22c. PHYSICIAN'S NAME (Type) <u>Harold R. Tritch, Jr., MD</u>			
22d. ADDRESS <u>302 N. Potomac Street-Hag., Md</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/20/62</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetary</u>				23d. LOCATION (City, town or county) <u>Clearspring Wash Co Md</u>				23e. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				24a. ADDRESS <u>Hagerstown Md.</u>				25a. DATE <u>FEB 21 '62</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

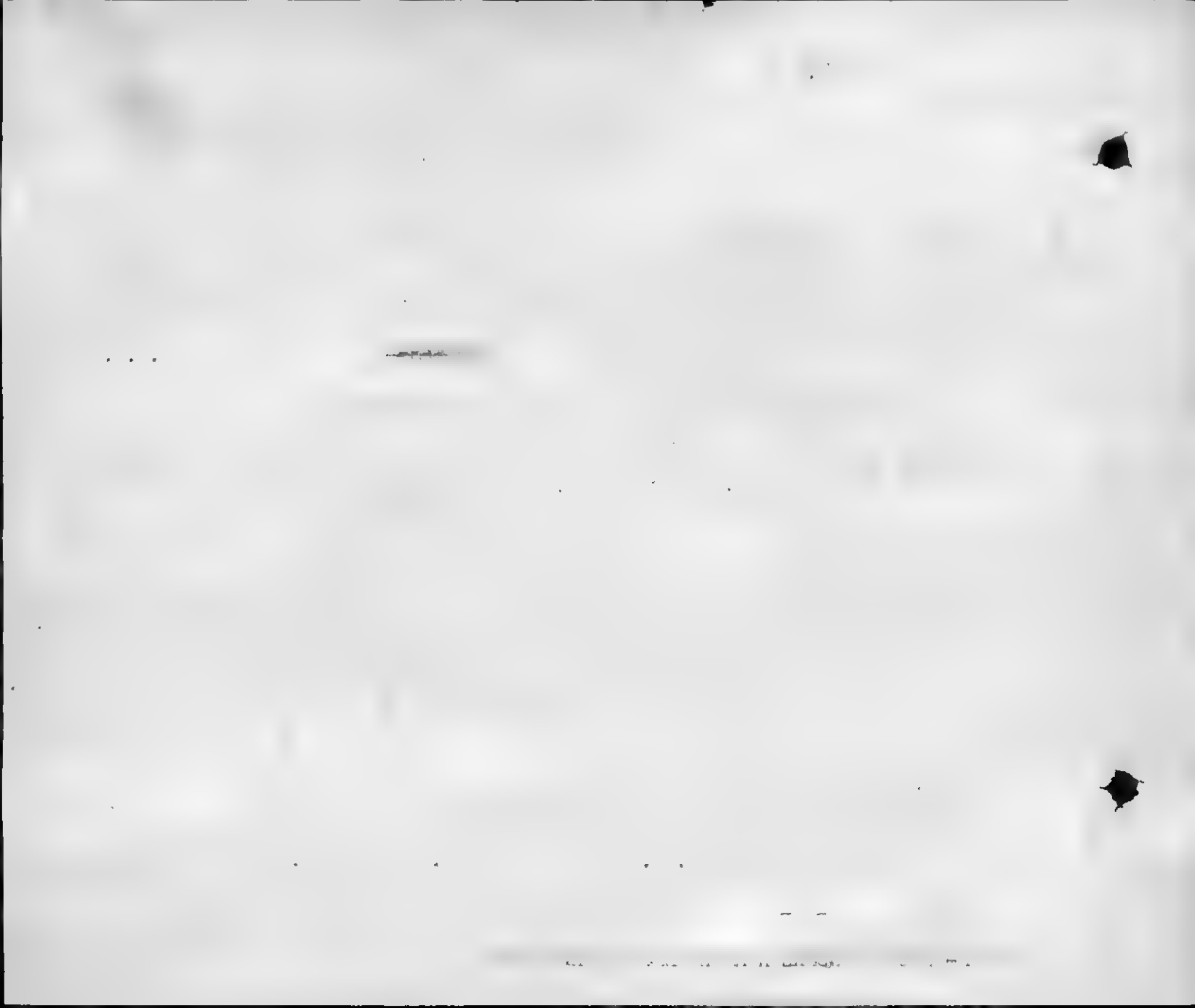
02404

02332

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b. 5 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 960 G MAIN AVENUE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 960 G MAIN AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLOTILDA ANN BUMBAUGH		4. DATE OF DEATH Month FEBRUARY Day 18 Year 19 62	
5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 16 1883 9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER 10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) LITTLESTOWN PENNA. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUSTUS LONG		14. MOTHER'S MAIDEN NAME MARY RIDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE 17. INFORMANT LOIS M BUMBAUGH HAGERSTOWN MARYLAND Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 420.0 DUE TO Arteriosclerosis heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Chronic Cystitis			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II, of Item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1958 , to Feb 18, 1962 , that (I) (we) last saw the deceased alive on Feb 18, 1962 , and that death occurred at 24 M. from the causes and on the date stated above.			
22a. SIGNATURE Paul Harrison		22b. DATE SIGNED 2/20/62	
22c. PHYSICIAN'S NAME (Type) PAUL HARRISON M. D.		22d. ADDRESS 318 N. POTOMAC ST. HAGERSTOWN MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-22-62	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town or county) HAGERSTOWN MARYLAND (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND		25a. REC'D BY REGISTRAR DATE FEB 26 '62 25b. REGISTRAR'S SIGNATURE _____	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The State requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



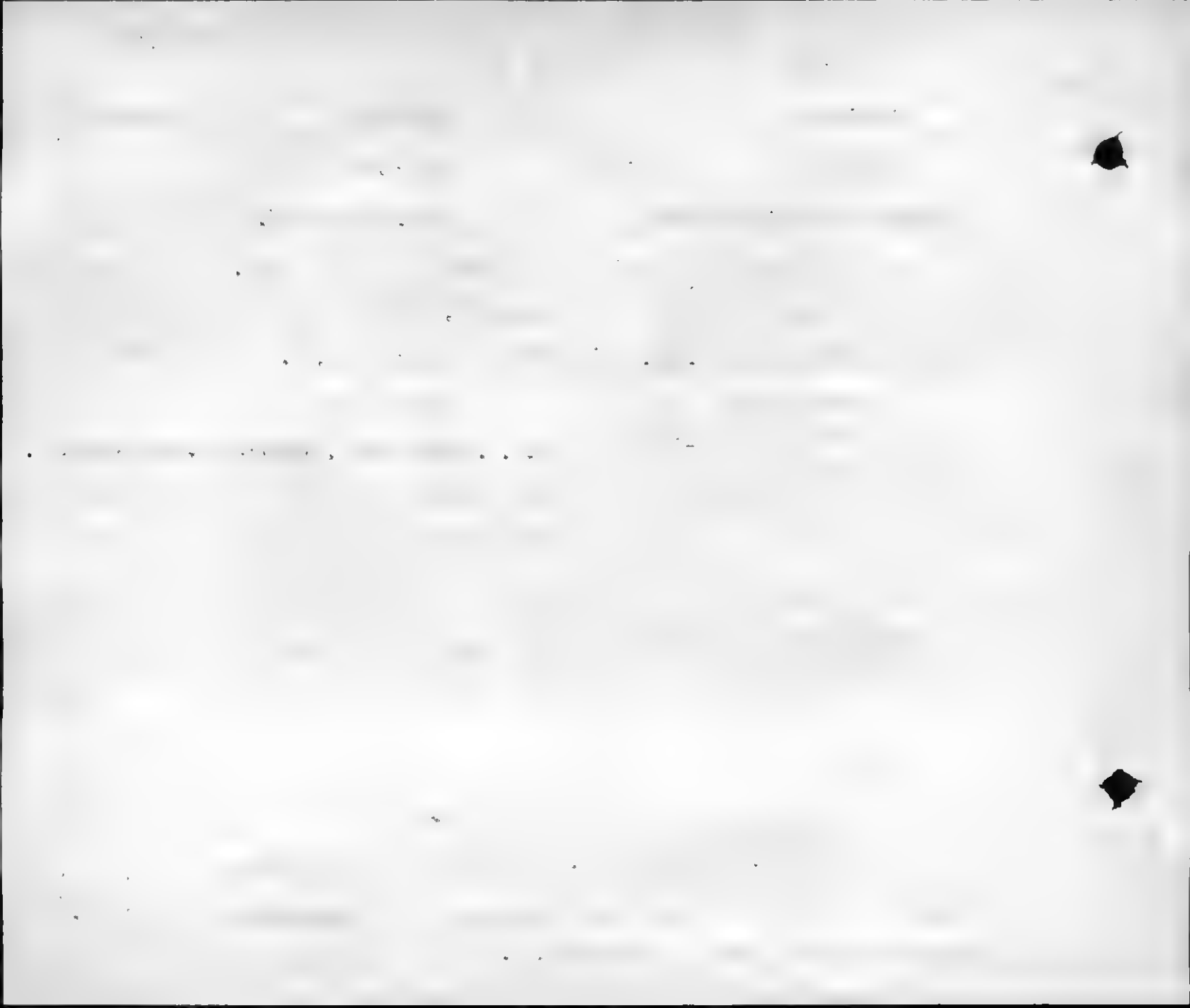
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS 14
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
02405
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>664 N. Prospect St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Erwin</u> Last <u>Burger</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1887</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furn. Mfg. & Aircraft</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Smithsburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Burger</u>		14. MOTHER'S MAIDEN NAME <u>Susan Popper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-3304</u>	
17. INFORMANT <u>Mrs. C.E. Burger</u>		Address <u>664 N. Prospect St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.1</u> DUE TO <u>Cox pulmonary (it ruled factors)</u>			
(b) <u>emphysema & arteriosclerosis of gall.</u>			
(c) <u>emphysema, bronchitis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>emphysema, bronchitis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (th's hospital) attended the deceased from....., 19.., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard N. Weeks, M.D.</u>		22b. DATE SIGNED <u>2/12/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		22d. ADDRESS <u>136 N. Potomac Street</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/12/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>Wm. A. Weeks</u>	
ADDRESS <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. A. Weeks</u>	
DATE <u>FEB 13 '62</u>		25c. REGISTRAR'S SIGNATURE <u>Wm. A. Weeks</u>	

Wm. A. Weeks



1 FOR STATE HEALTH DEPT.

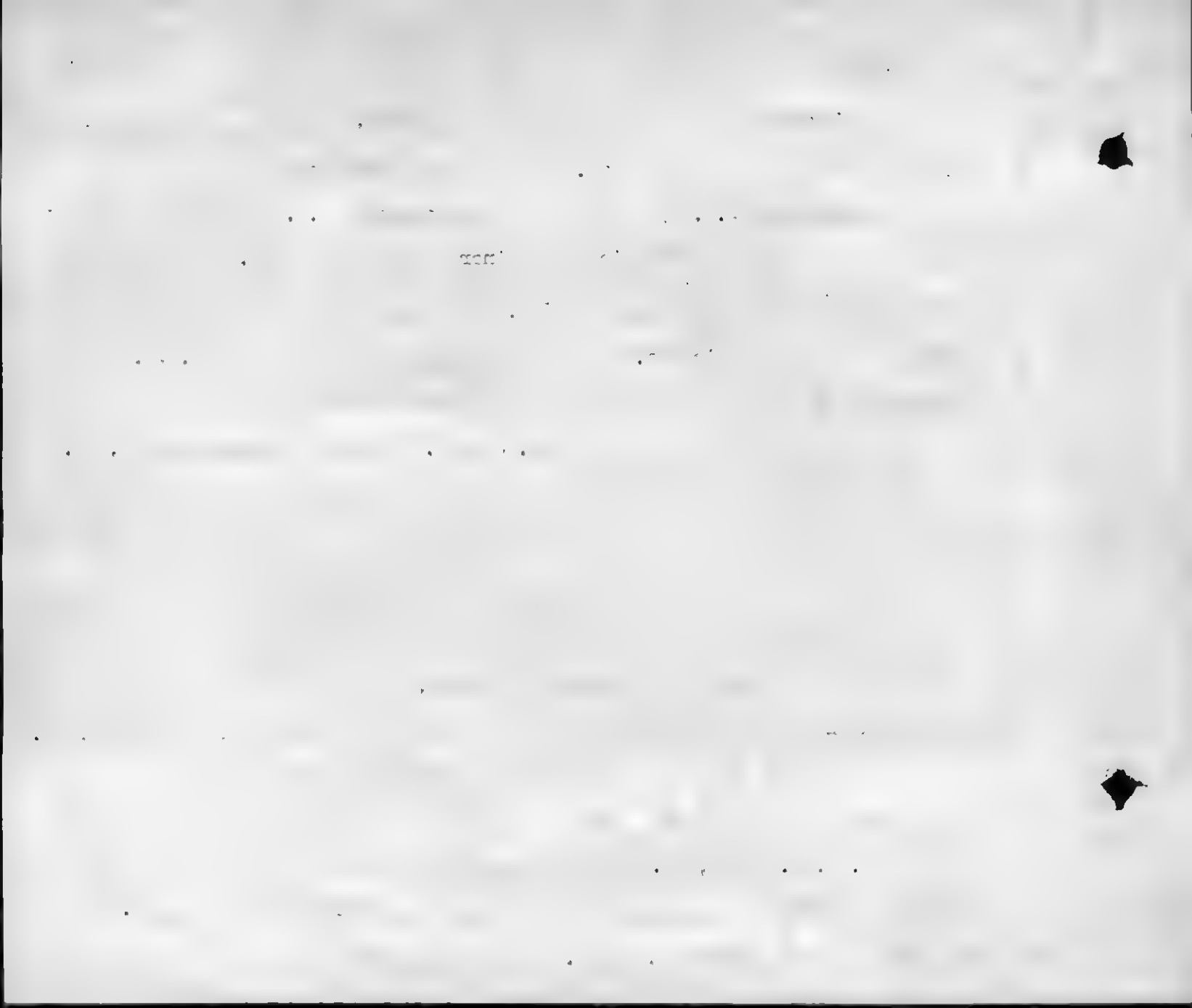
TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02406 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02394

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>22 yrs.</u>				d. STREET ADDRESS <u>Hagerstown R.D. #5</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hagerstown R.D. #5</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Frederick Cantner</u>		4. DATE OF DEATH <u>Feb. 23 1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 17, 1914</u>		9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frick Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Cantner</u>		14. MOTHER'S MAIDEN NAME <u>Florence Saunders</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. John F. Cantner</u>		Address <u>Hagerstown #5, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound Of Chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted wound of chest.</u>					
20c. TIME OF INJURY Month, Day, Year <u>Noon 2-23-1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Route 5 Hagerstown, Washington, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2-24-62</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>Hagerstown #5 Md.</u>		(State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ringgold</u>		22d. LOCATION (City, town, or country) (State) <u>Hagerstown #5 Md.</u>	
23. FUNERAL DIRECTOR <u>Walter J. Hove</u>				ADDRESS <u>Waynesboro, Penna.</u>		24a. REC'D BY REGISTRAR <u>FEB 27 1962</u>	
				24b. REGISTRAR'S SIGNATURE <u>Walter J. Hove</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

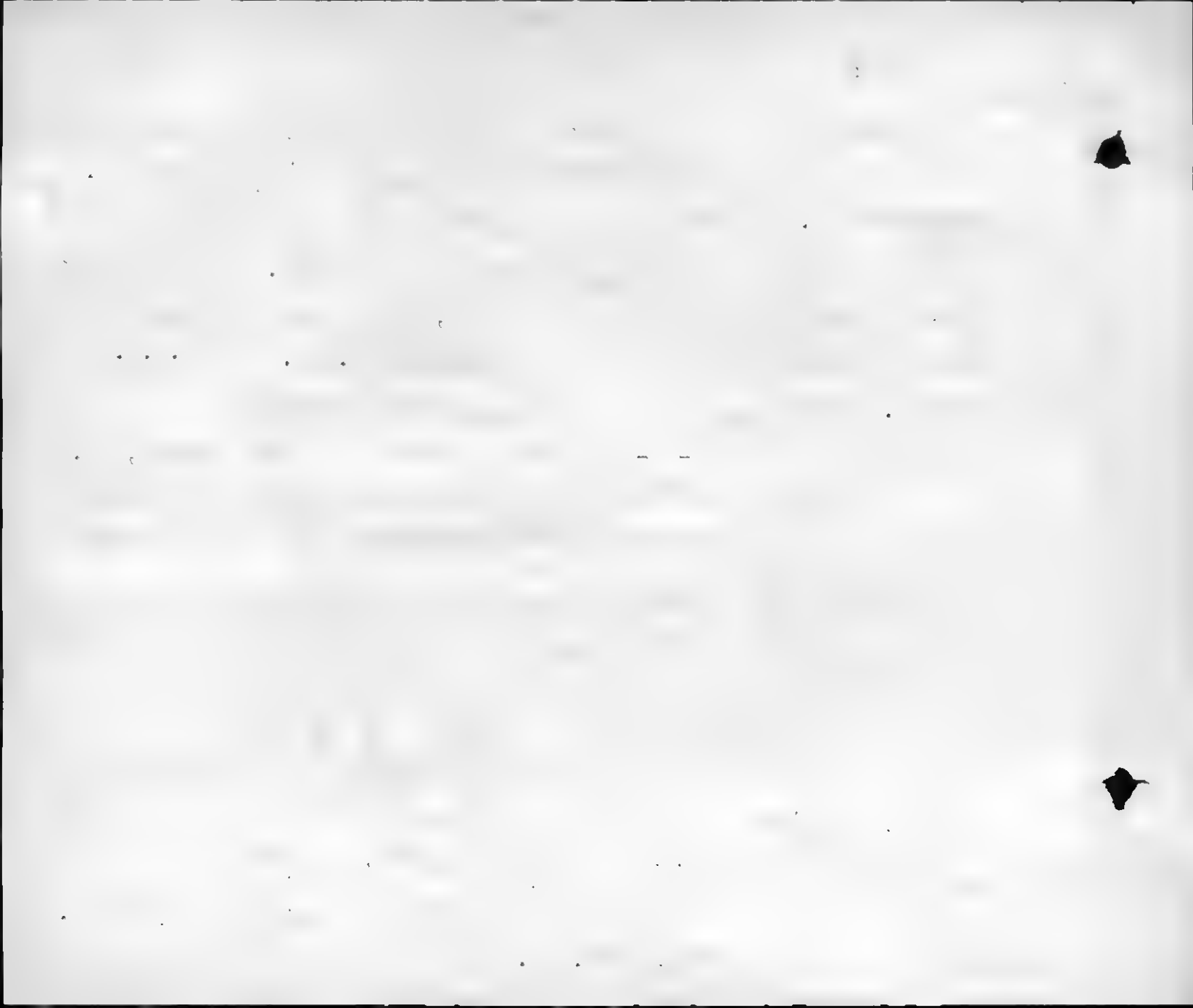
CERTIFICATE OF DEATH

02407

02395

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN <u>FEW MINUTES</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON CO. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING, MD.</u> d. STREET ADDRESS <u>NONE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VERNIE GRACE CARBAUGH</u> 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 10, 1898</u> 9. AGE (In years last birthday) <u>63</u> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME DUTIES</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON CO. MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH <u>FEB. 24 19 62</u> 13. FATHER'S NAME <u>JOHN H. CARBAUGH</u> 14. MOTHER'S MAIDEN NAME <u>IDA MAY CLOPPER</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>213-40-4700</u> 17. INFORMANT <u>MRS OLIVE HULL</u> Address <u>CLEAR SPRING, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>CORONARY ARTERY OCCLUSION WITH MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Interval between onset and death <u>2 hours.</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year <u>February 21 19 62</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>CLEAR SPRING, Maryland</u> 20f. (City or town) <u>CLEAR SPRING</u> (County) <u>MARYLAND</u> (State) <u>MD.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>February 21 19 62</u> to <u>Feb 24 19 62</u> that (I) (we) last saw the deceased alive on <u>February 24 19 62</u> and that death occurred at <u>10:10 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Archie Robert Cohen</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>		22b. DATE SIGNED <u>02/26/62</u> 22d. ADDRESS <u>Clear Spring, Maryland</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2/27/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BLAIRS VALLEY CEMETERY</u> 23d. LOCATION (City, town or county) <u>BLAIRS VALLEY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Margaret Rowland</u> ADDRESS <u>CLEAR SPRING, MD.</u> 25a. REC'D BY REGISTRAR <u>C. L. H. Hines</u> 25b. REGISTRAR'S SIGNATURE <u>C. L. H. Hines</u>		25c. DATE <u>FEB 28 '62</u>	

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a funeral-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

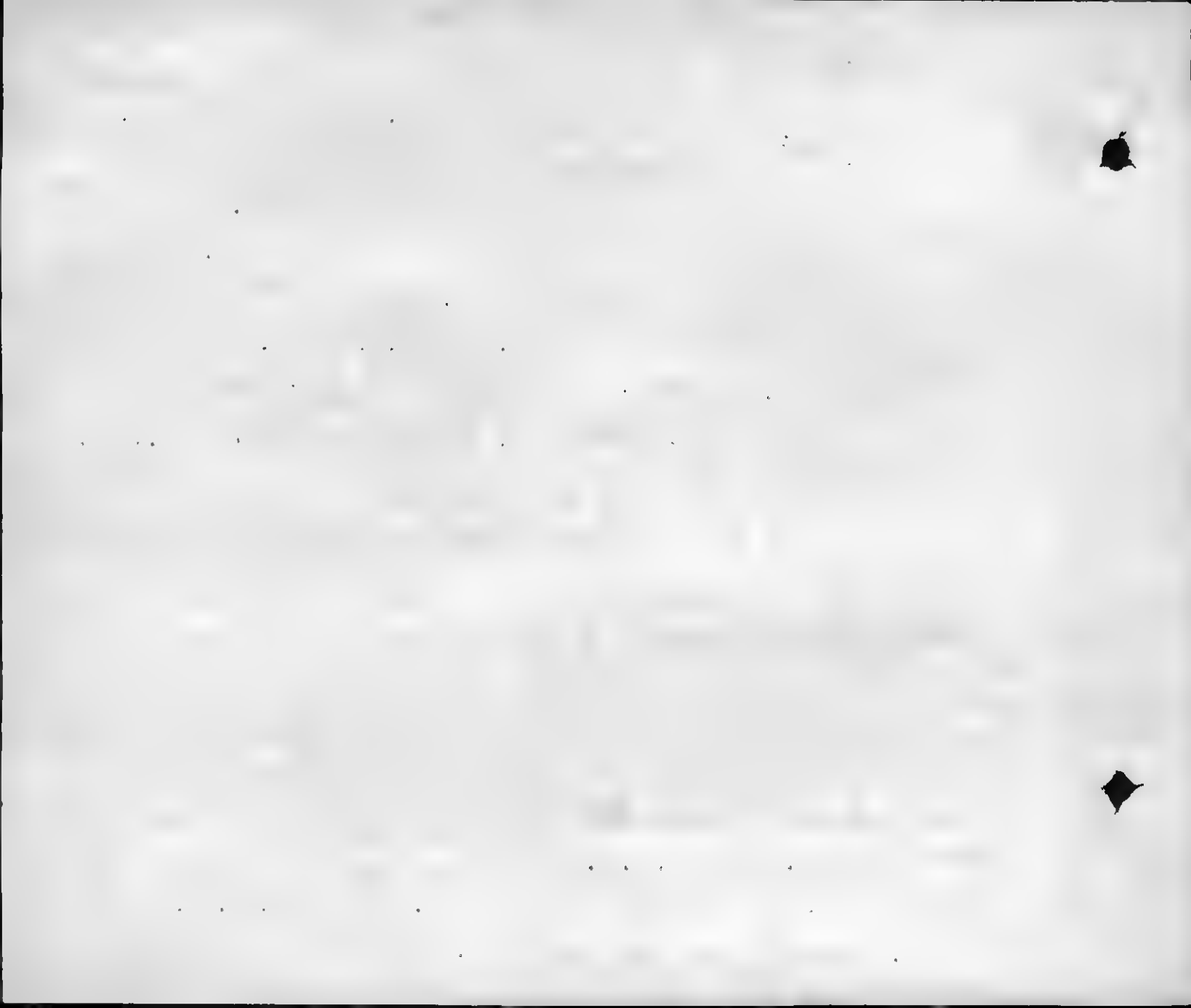
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02396

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 7 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9 Marbern Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 925 Hagerstown d. STREET ADDRESS 925 Hamilton Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roy Milton Christner		4. DATE OF DEATH Month Feb. 14, Day 19 Year 62			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 15, 1892		9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 19 Hours 62 Mn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance		10b. KIND OF BUSINESS OR INDUSTRY West. Union Tele. Garrett, Penna.		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Austin G. Christner		14. MOTHER'S MAIDEN NAME Lydia Burkholder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. 233-01-2296		17. INFORMANT Mrs Kathleen Christner, Hag., Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Generalized atherosclerosis DUE TO (c) Nodular hyaline plaque, Diverticular sigmoid colon		INTERVAL BETWEEN ONSET AND DEATH 3c Hrs			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/16/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Feb. 19, 1962		22c. NAME OF CEMETERY OR CREMATORY Halcyon Hills Mem. Wheeling, W.Va.	
23. FUNERAL DIRECTOR Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REG STRAR FEB 19 '62		24b. REGISTRAR'S SIGNATURE Arthur E. Hanna	



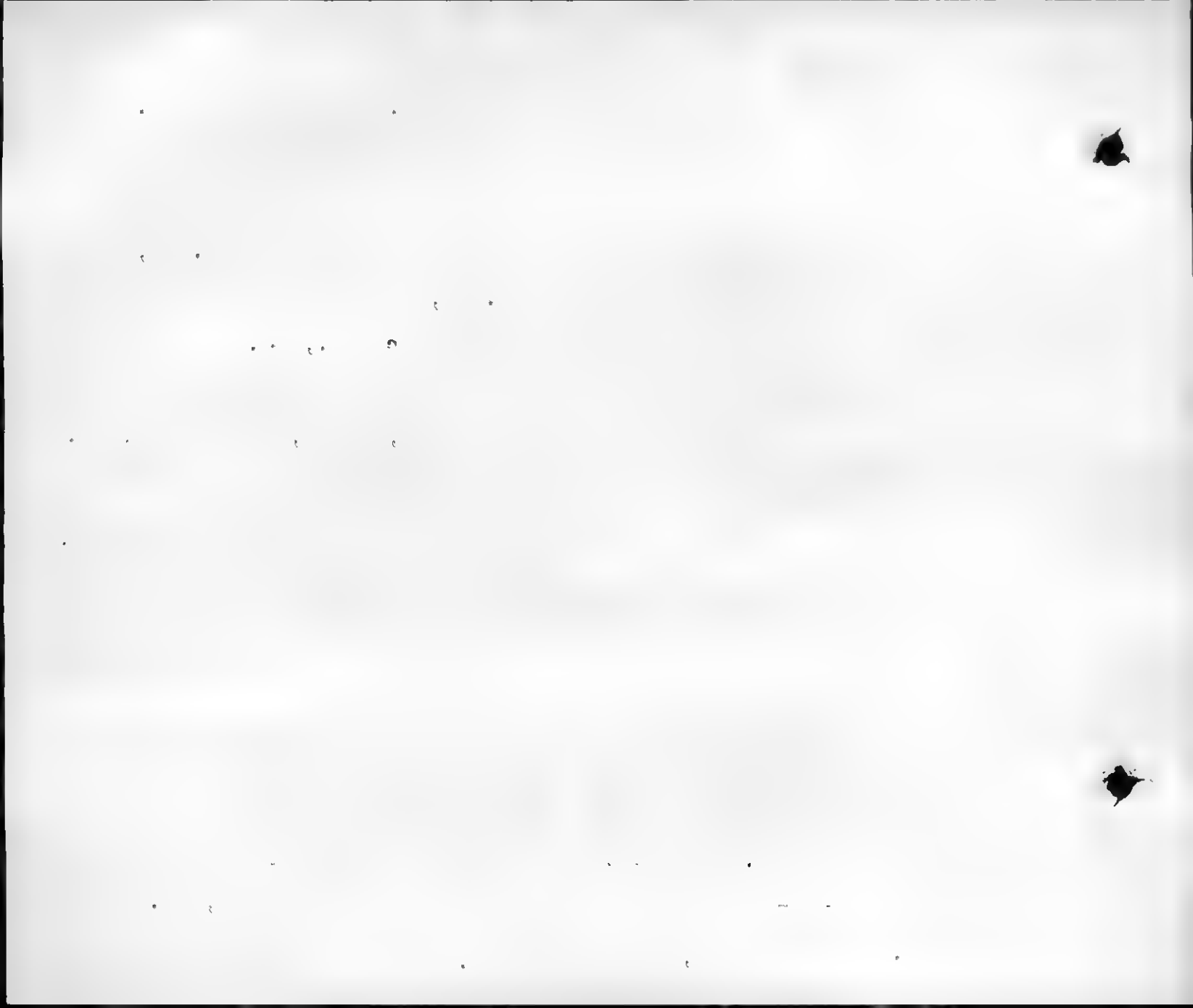
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02397

02409

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg d. STREET ADDRESS RFD 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amanda Middle NMN Last Cline			4. DATE OF DEATH Month Feb. 14, Day 19 Year 62				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1878		9. AGE (In years last birthday) 83 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co., Md.			
13. FATHER'S NAME Sam Frey			14. MOTHER'S MAIDEN NAME Sophia Kuhn				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Hubert Cline, RFD 1, Smithsburg, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 2 wks.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from 1-17-62 to 2-13-62 that (I) (we) last saw the deceased alive on 1-17-62 and that death occurred at 2:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Charles F. Hess 22c. PHYSICIAN'S NAME (Type) _____			22b. DATE SIGNED 2/15/62 22d. ADDRESS _____ M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION REMOVAL (Specify) burial		23b. DATE THEREOF 2-17-62		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Church 23d. LOCATION (City, town, or county) Smithsburg, Md. (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md. ADDRESS _____			25a. REC'D BY REGISTRAR DATE FEB 19 '62		25b. REGISTRAR'S SIGNATURE _____		



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

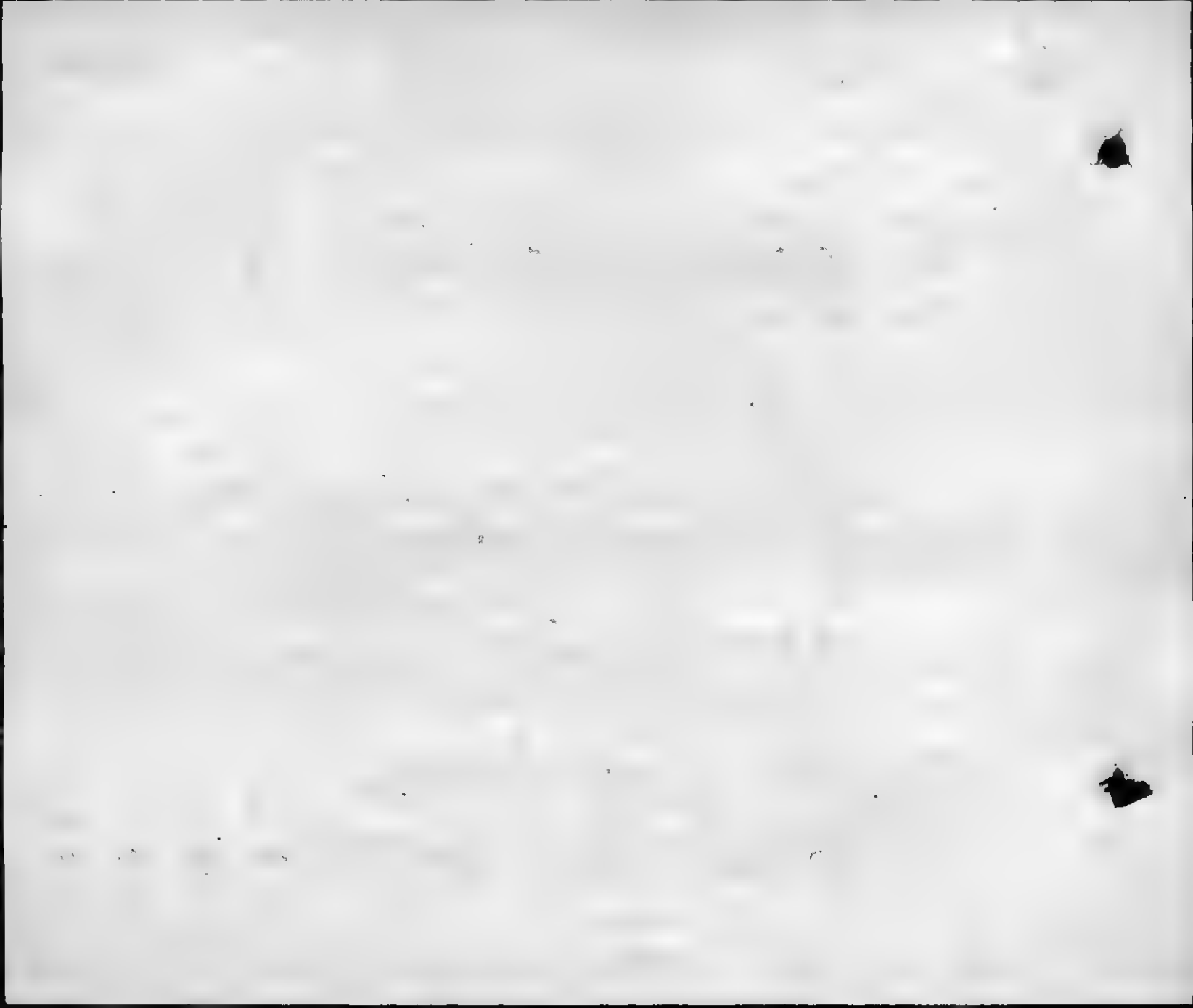
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02410

02398

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>WASHINGTON</u></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u></p> <p>c. LENGTH OF STAY IN <u>MD.</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTERN MARYLAND STATE HOSPITAL</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>MARYLAND</u></p> <p>b. COUNTY <u>WASHINGTON</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>YARROWSBURG</u></p> <p>d. STREET ADDRESS <u>KNOXVILLE MD. 17.1</u></p>		<p>6. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) <u>Helen ELIZABETH COBLENTZ</u></p> <p>5. SEX <u>FEMALE</u></p> <p>6. COLOR OR RACE <u>WHITE</u></p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>JANUARY 15, 1910</u></p> <p>9. AGE (In years last birthday) <u>52</u> yrs. <u>0</u> months <u>26</u> days</p>		<p>4. DATE OF DEATH <u>Feb. 11, 1962</u></p> <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u></p> <p>11. BIRTHPLACE (County & State or foreign country) <u>BRUNSWICK FORD CO. MD.</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		
<p>13. FATHER'S NAME <u>JOSEPH NUSE</u></p> <p>14. MOTHER'S MAIDEN NAME <u>EMMA DANNER</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u></p> <p>16. SOCIAL SECURITY NO. <u>NONE</u></p> <p>17. INFORMANT <u>GEORGE A. COBLENTZ</u> Address <u>(HUSBAND)</u></p>		
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u></p> <p>Conditions, if any, which gave rise to immediate cause (b) <u>Coronary atherosclerosis</u></p> <p>(c) <u>Diabetes mellitus</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u></p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)</p>		
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>		<p>21. I certify that (I) (this hospital) attended the deceased from <u>January 30, 1962</u> to <u>Feb. 11, 1962</u> that (I) <u>was</u> last saw the deceased alive on <u>Feb. 11, 1962</u> and that death occurred at <u>4:10 A.M.</u> from the causes and on the date stated above.</p>		
<p>22a. SIGNATURE <u>Young E. Chun</u></p> <p>22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u></p>		<p>22b. ADDRESS <u>1500 Penna. Ave Hagerstown, Md.</u></p> <p>22d. DATE SIGNED <u>Feb. 11, 1962</u></p>		
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p> <p>23b. DATE THEREOF <u>FEB. 14, 1962</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>BROWNSVILLE HTS. CEMETERY</u></p> <p>23d. LOCATION (City, town or county) (State) <u>BROWNSVILLE WASH. CO. MD.</u></p>		<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. East</u></p> <p>25. REC'D BY REGISTRAR <u>Feb 16 '62</u></p> <p>25b. REGISTRAR'S SIGNATURE <u>John S. Hume</u></p>		



1
TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

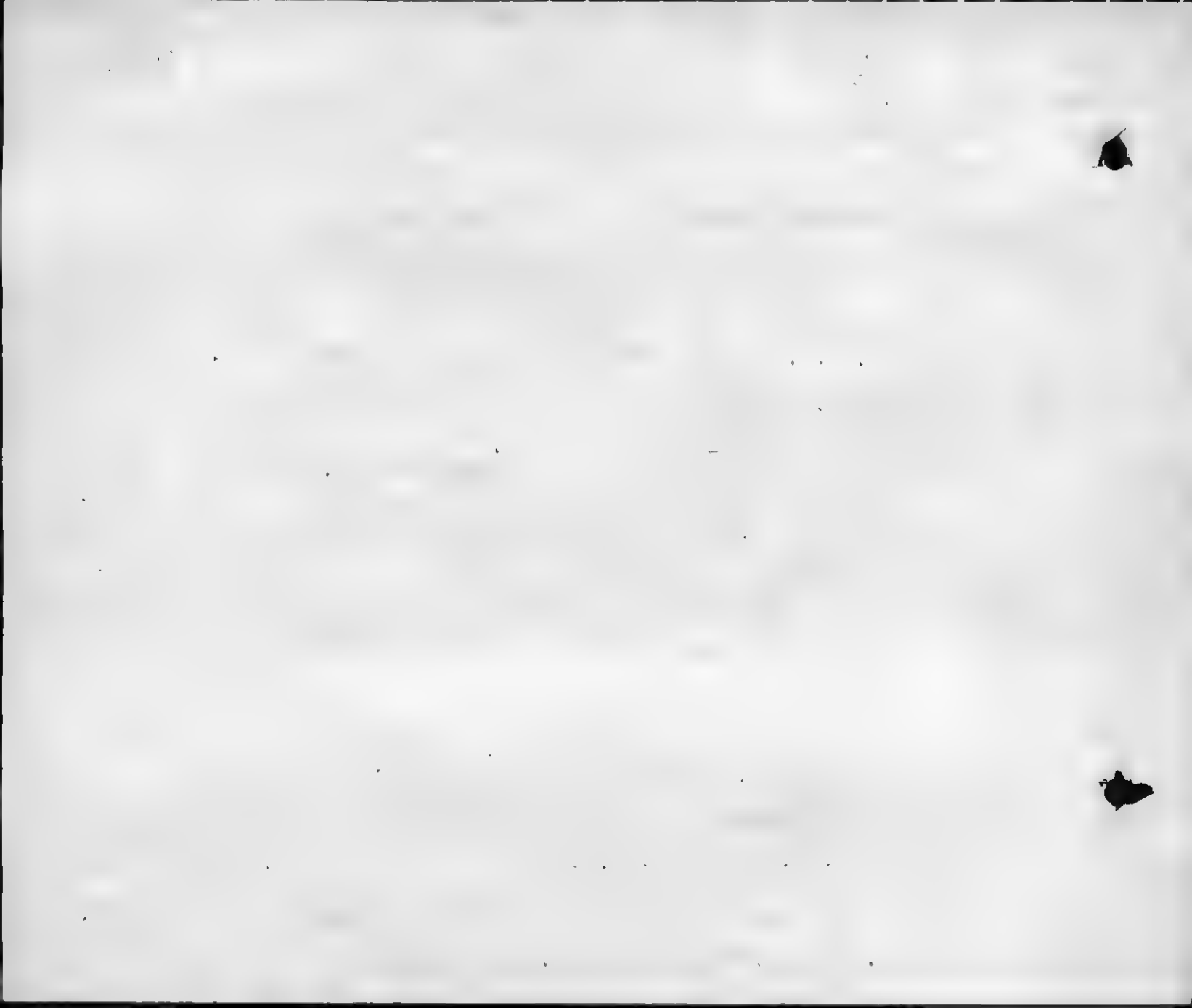
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02411

CERTIFICATE OF DEATH

02399

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN b 12 Hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
d. STREET ADDRESS 851 Penna Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) HOWARD WILLIAM CRAMER
4. DATE OF DEATH Feby 12 1962 19
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Dec 18 1891 70 yrs.
9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept Supt. M.P. Moller Co Retired
10b. KIND OF BUSINESS OR INDUSTRY 1. PLACE of Birth Wash Co Md. 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William F. Cramer 14. MOTHER'S MAIDEN NAME Rebecca Semler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 214-09-1122 17. INFORMANT Mrs M. Ruth Cramer 851 Penna Ave Hagerstown Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism
DUE TO (b) Venous thrombosis iliac vein right
DUE TO (c) 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 30, 1962, to Feb. 12, 1962, that (I) (we) last saw the deceased alive on Feb. 12, 1962, and that death occurred at 8:45 P.M. from the causes and on the date stated above.
22a. SIGNATURE B. B. Kneisley, M.D. 22b. DATE SIGNED 2/13/62
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D. 22d. ADDRESS 148 West Washington Street Hagerstown, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/15/62 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery Hagerstown Wash Co Md.
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
DATE FEB 16 '62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

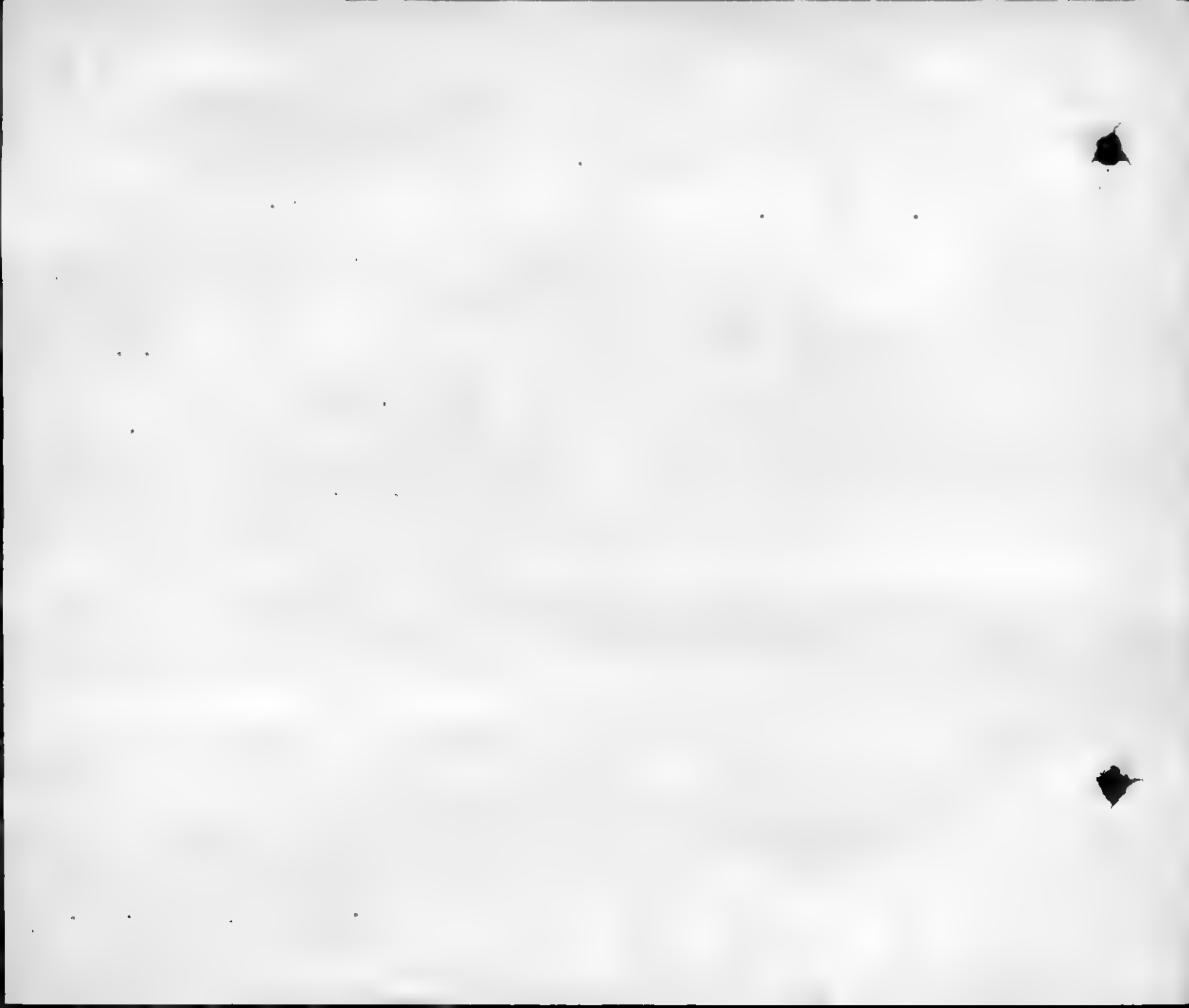
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02412

02:00

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN b. 20 YRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 320 W. HOWARD ST.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 320 W. HOWARD ST.	
3. NAME OF DECEASED (Type or print) IDA LEE CRIM		4. DATE OF DEATH FEBRUARY 17 1962	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/5/1879	
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME RUFUS SMITH CRIM		14. MOTHER'S MAIDEN NAME SARAH C. MULL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MI. JOHN UNGER		18. ADDRESS HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Adeno Carcinoma of Breast 1959 Metastasis 1960		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 7, 1959 to Feb 17, 1962 ; that (I) (we) last saw the deceased alive on Feb 17, 1962 , and that death occurred at 5 AM , from the causes and on the date stated above			
22a. SIGNATURE Robert P. Conrad M.D.		22b. DATE SIGNED 2-18-62	
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad, M.D.		22d. ADDRESS 137 W. Washington St Hagerstown Md	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/19/62	
23c. NAME OF CEMETERY OR CREMATORY BAKERSVILLE CHURCH CEM.		23d. LOCATION (City, town or county) (State) WASHINGTON CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md		25a. REC'D BY REGISTRAR FEB 21 '62	
25b. REGISTRAR'S SIGNATURE		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02413

02101

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b. 62 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 508 Summit Ave		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 508 Summit Ave	
3. NAME OF DECEASED (Type or print) Charles William De Lauder First Middle Last 4. DATE OF DEATH February 7 1962 Month Day Year 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 5, 1870 <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) 91 yrs. Months Days Hours Min.		10a. USJA, OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker 10b. KIND OF BUSINESS OR INDUSTRY Organ 11. BIRTHPLACE (County & State or foreign country) Myersville, Md. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John H. De Lauder 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Rebecca Renner 16. SOCIAL SECURITY NO 220-10-3537 17. INFORMANT Miss Ethel B. De Lauder Address Hag. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with congestive failure 42 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 2-3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Jan. 22, 1962 to Feb. 7, 1962, that (I) (we) last saw the deceased alive on Feb. 5, 1962, and that death occurred at 12:40 P.M., from the causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley		22b. DATE Feb. 8, 1962	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-10-62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown, Md.		25a. REC'D BY REGISTRAR Feb 13 '62	
25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL, TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

024102

02414

1. PLACE OF DEATH
a. COUNTY **WASHINGTON** b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **HAGERSTOWN** c. LENGTH OF STAY IN b. **14 DAYS**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **WASHINGTON COUNTY HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **MARYLAND** b. COUNTY **WASHINGTON**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **RURAL ROUTE #2 HAGERSTOWN**
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First **LESLIE** Middle **MONTAGUE** Last **DICK**

4. DATE OF DEATH Month **FEBRUARY** Day **4** Year **19 62**

5. SEX **MALE** **WHITE** **WIDOWED** ☐ **DIVORCED** ☐ **6. COLOR OR RACE** **WHITE** **7. MARRIED** ☒ **NEVER MARRIED** ☐

8. DATE OF BIRTH **MARCH 15, 1905** **9. AGE** (In years last birthday) **56** yrs. **10. BIRTHPLACE** (County & State, or foreign country) **FREDERICK COUNTY VIRGINIA** **11. CITIZEN OF WHAT COUNTRY?** **U.S.A.**

12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **CARPENTER** **12b. KIND OF BUSINESS OR INDUSTRY** **CONSTRUCTION**

13. FATHER'S NAME **THOMAS JEFFERSON DICK** **14. MOTHER'S MAIDEN NAME** **ALICE SHIRLEY**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **YES** **WW II** **16. SOCIAL SECURITY NO.** **236-01-9209** **17. INFORMANT** **MRS. LESLIE M DICK ROUTE 2 HAGERSTOWN MD** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Acute peritonitis!**
78X DUE TO **Rupture of transverse colon.**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) **INTERVAL BETWEEN ONSET AND DEATH** **3-4 days**
DUE TO (c) **4 days**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Arteriosclerotic heart disease - coronary artery**
Old myocardial infarction

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (If nature of injury is not for Part II of this certificate)
20c. TIME OF INJURY Month, Day, Year **19** **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** **20g. (County)** **20h. (State)**

21. I certify that (I) (this hospital) attended the deceased from **4 Feb 62** **to** **4 Feb 62** **that (I) (we) last saw the deceased alive on** **4 Feb 62** **and that death occurred at** **6:15 P** **from the causes and on the date stated above.**

22a. SIGNATURE **22b. DATE SIGNED**
22c. PHYSICIAN'S NAME (Type) **RICHARD T BINFORD M. D.** **22d. ADDRESS** **1135 POTOMAC AVE. HAGERSTOWN MARYLAND**

23a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** **23b. DATE THEREOF** **2-7-62** **23c. NAME OF CEMETERY OR CREMATORY** **GREENWAY CEMETERY** **23d. LOCATION (City, town or county)** **BERKELEY SPRINGS WEST VIRGINIA** (State)

24. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** **25a. REC'D BY REGISTRAR** **25b. REGISTRAR'S SIGNATURE**
SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND **DATE** **FEB 14 '62**



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Account of the ...
 Report of the ...

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MARYLAND STATE DEPARTMENT OF HEALTH

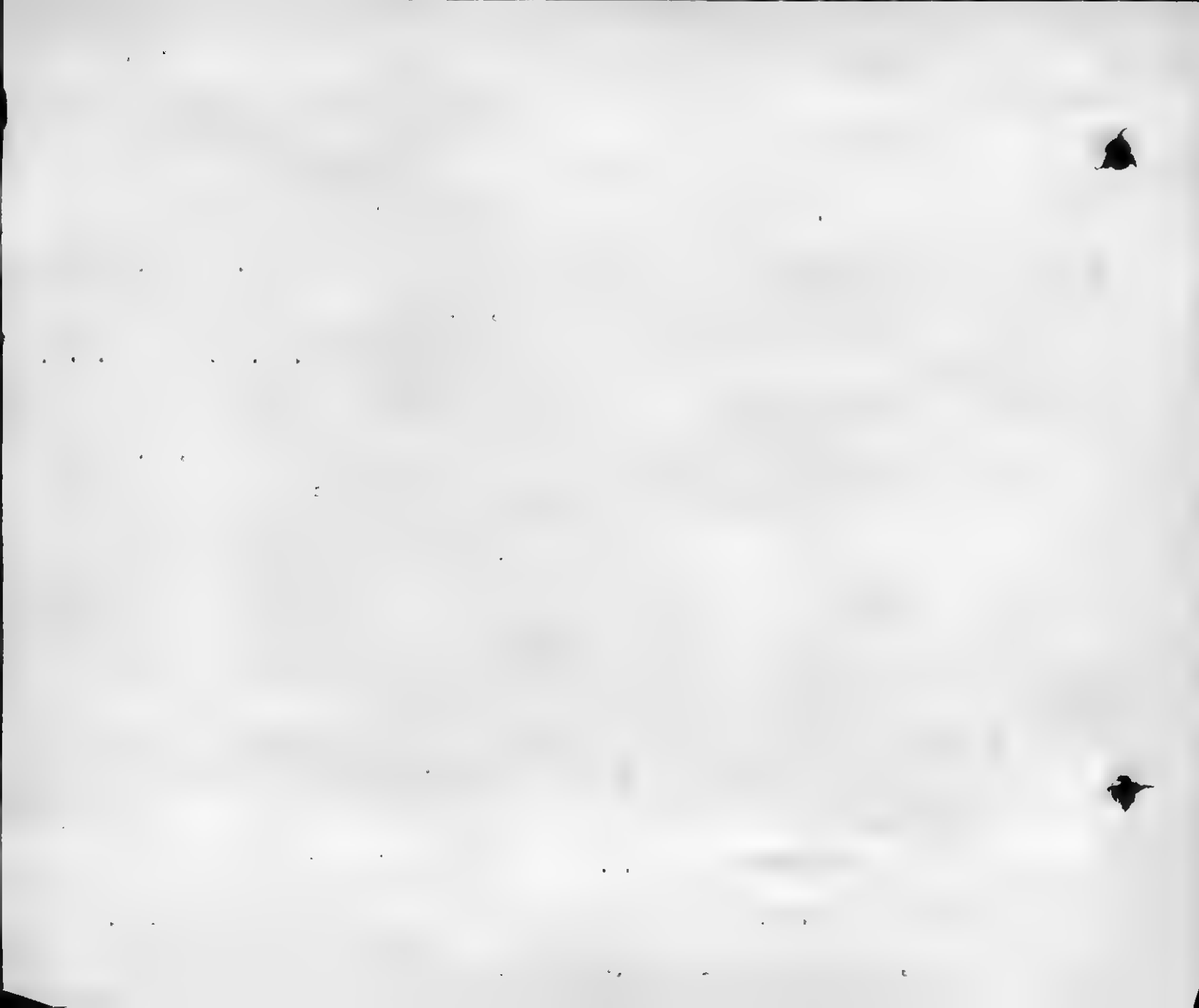
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02415

02403

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b. <u>5 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clearspring, R#1</u> d. STREET ADDRESS <u>Western Pike</u> e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Milton Berry Doub</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan, 26, 1888</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <u>74</u> yrs. Months Days Hours Min.		4. DATE OF DEATH <u>Feb. 8, 1962</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. PLACE of birth <u>Hagerstown Wash. Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel W Doub</u> 14. MOTHER'S MAIDEN NAME <u>Elton Berry</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>220-34-0875</u> 17. INFORMANT <u>Mrs June Doub Clearspring, Md. R#1</u> Address <u>Interval Between Onset and Death</u> <u>12 hours</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery occlusion with myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Hypertensive arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>Jan 20</u> Hour a.m. p.m. <u>3:35 AM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Clear Spring, Maryland</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 20</u> <u>1962</u> <u>3:35 AM</u> to <u>Feb 08</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>February 08 1962</u> and that death occurred at <u>3:35 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Archie Robert Cohen</u> 22b. PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Clear Spring, Maryland</u> 22e. DATE SIGNED <u>Feb 09, 1962</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb. 11, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Harper Cemetery</u> 23d. LOCATION (City, town or county) <u>Harper Ferry W. Va.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Maryland</u> 25a. REC'D BY REGISTRAR <u>Feb 13 '62</u> 25b. REGISTRAR'S SIGNATURE	



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MARYLAND STATE DEPARTMENT OF HEALTH

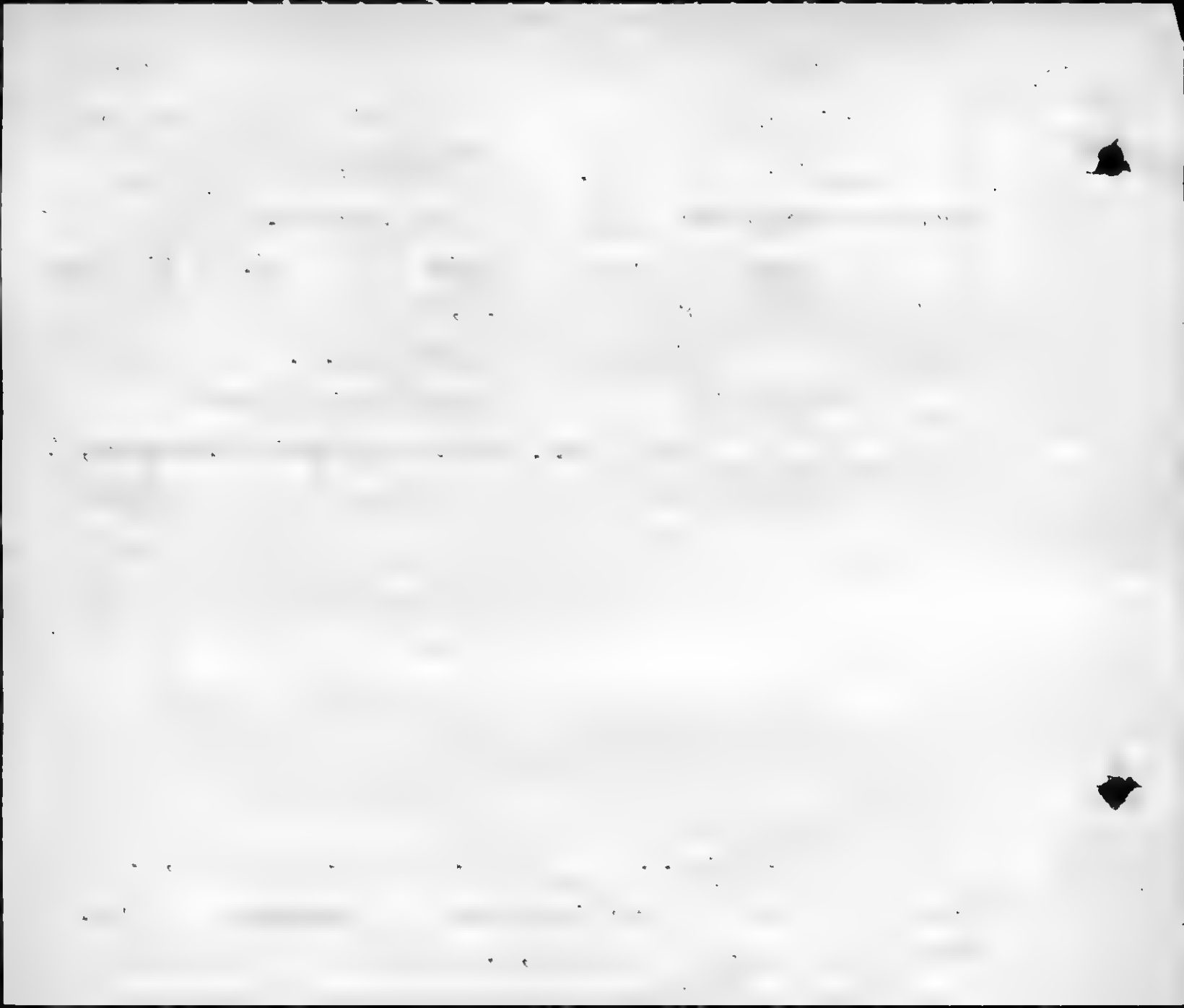
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02416

02404

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> <u>Downsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>4 1/2 mos.</u>		d. STREET ADDRESS <u>551 W. Howard St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Woburn Manor Boarding Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) First <u>Jacob</u> Middle <u>Luther</u> Last <u>Eckstine</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>25</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1875</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		9b. AGE (In years last birthday) <u>86</u> yrs.	
10a. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co. Md.</u>	
13. FATHER'S NAME <u>Jacob Eckstine</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Virginia Startzman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>W.D. Cutchall</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Ac. MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>2/25/62</u> to <u>2/25/62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/25/62</u> , 19 <u>62</u> , and that death occurred at <u>7:00</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Ralph F. Young</u>		22b. DATE SIGNED <u>2/27/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph F. Young M.D.</u>		22d. ADDRESS <u>101 E. Potomac St. Williamsport, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/27/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) _____ (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> <u>Wm. G. Horst</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 28 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>William G. Horst</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

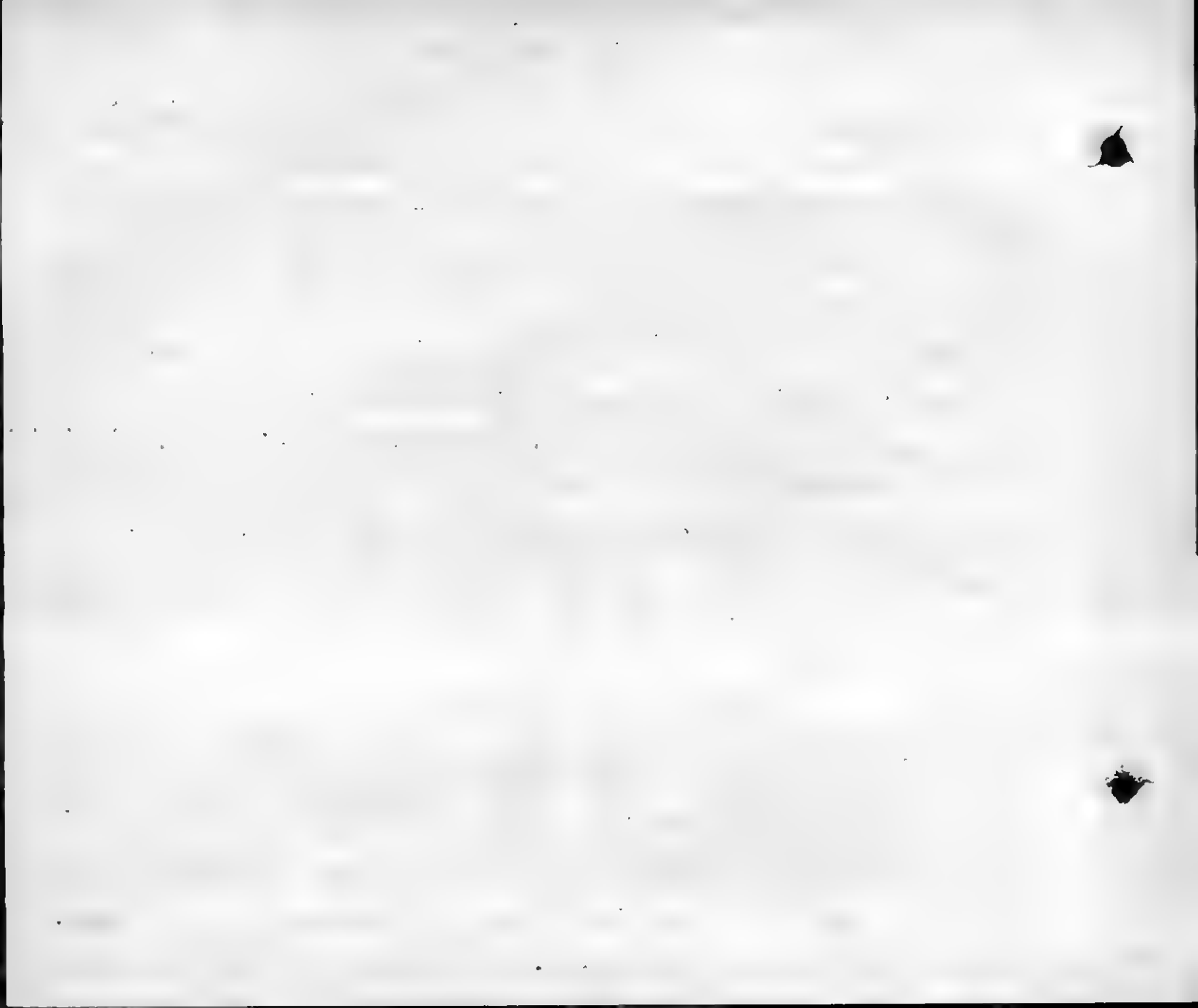
02417

CERTIFICATE OF DEATH

02405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Fahrney-Keedy Memorial Home	
3. NAME OF DECEASED (Type or print) First LETTIE Middle GEARHART Last GEARHART		4. DATE OF DEATH Month Feb Day 6 Year 1962	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/8/1902
9. AGE (In years last birthday) 59 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Arts & Crafts, Volunteer worker	
11. BIRTHPLACE (State or foreign country) Washington County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward J. Gearhart		14. MOTHER'S MAIDEN NAME Margaret Musselman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs. George Kunz, Fahrney-Keedy Home		Address Boonsboro, Md. R.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic PNEUMONIA 154 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, Rectosigmoidum, in Metastasis DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis left iliac external vein and lungs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-8 , 19 62 , to FEB 6 , 19 62 , that I last saw the deceased alive on FEB 6 , 19 62 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. R. LADHIZABAL		ADDRESS (Street, city or town, state) Smithsburg, Md	
PHYSICIAN'S NAME (Type) E. R. LADHIZABAL		DATE SIGNED 2-7-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/62	
22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) (State) Waynesboro Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Nathaniel Z. Green		24a. REC'D BY REGISTRAR DATE 1-3 '62	
ADDRESS Waynesboro, Pa.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

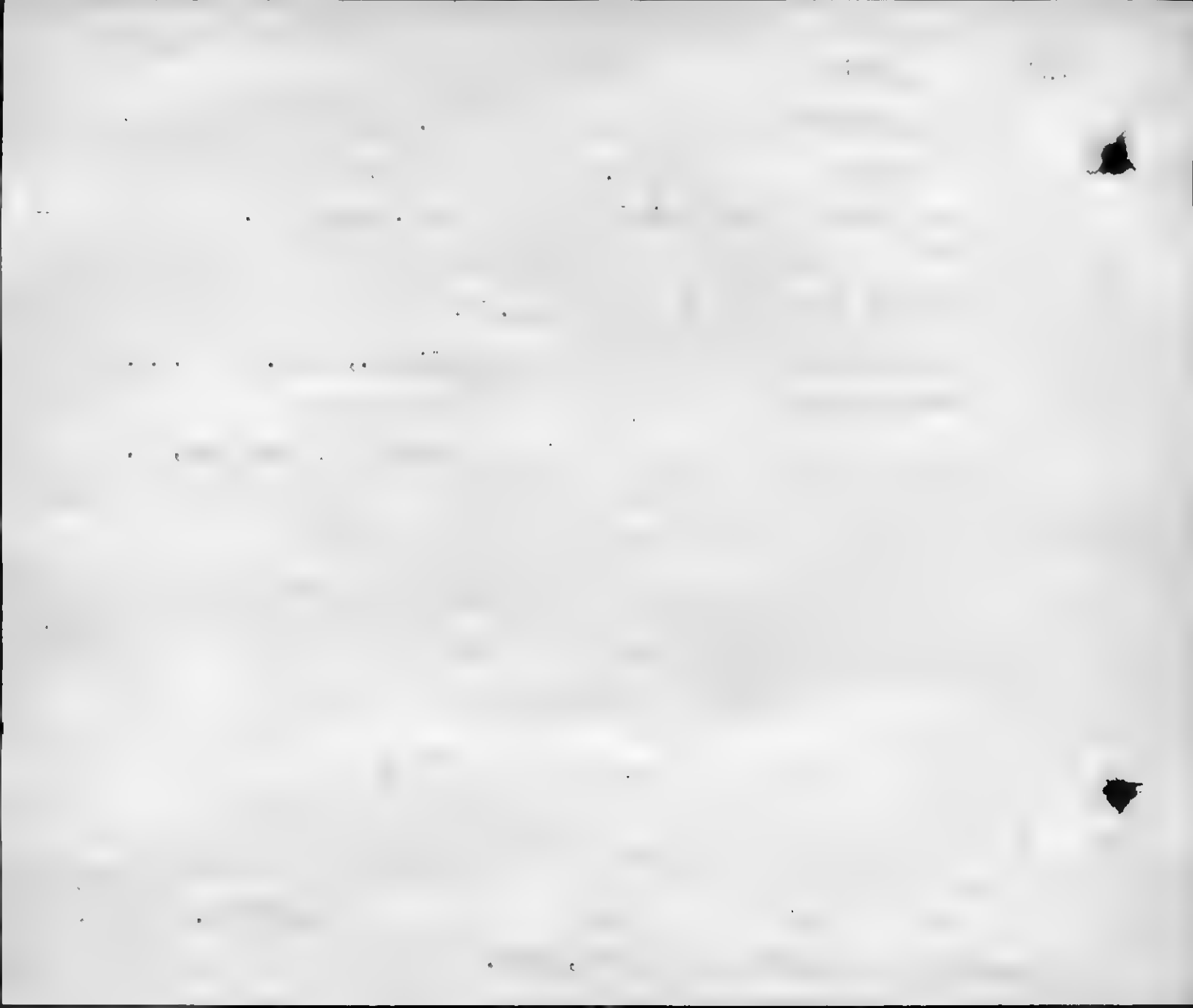
VR A15 (4)
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MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if Institutions: Residence before admission)			
a. COUNTY				a. STATE			
Washington				Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
Hagerstown				Washington			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
1 yr.				Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
Western Maryland State Hospital				205 E. Franklin St.			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
Elsie Catherine Geyer				Feb. 27, 1962			
5. SEX				6. COLOR OR RACE			
Female				White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				Sept. 12, 1883			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (County & State or foreign country)			
Housewife				Franklin Co., Penna.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Stephen McFerren				Missouri Welsh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
No				Miss Ethel Geyer			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				19. INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:				4 Days			
(a) IMMEDIATE CAUSE (a)				1 YEAR			
X DUE TO				UNKNOWN			
(b) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause (a).							
DUE TO							
(c) GENERALIZED ARTERIOSCLEROSIS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED?			
DIABETES MELLITUS -				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour a.m. p.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
19				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
21. I certify that (I) (this hospital) attended the deceased from March 28, 1961, to Feb. 27, 1962, that (I) (the) last saw the deceased alive on Feb. 27, 1962, and that death occurred at 6:45 AM, from the causes and on the date stated above.				21d. (City or town) (County) (State)			
22a. SIGNATURE				22b. DATE SIGNED			
Antonio U. Pallagrosi				M.D.			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
ANTONIO U. PALLAGROSI				Western Ind. State Hospital Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
Burial				3/1/62			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
Quincy				Franklin Co., Penna.			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
Walter J. Gure				25b. REGISTRAR'S SIGNATURE			
Waynesboro, Penna.				DATE MAR 1 '62			

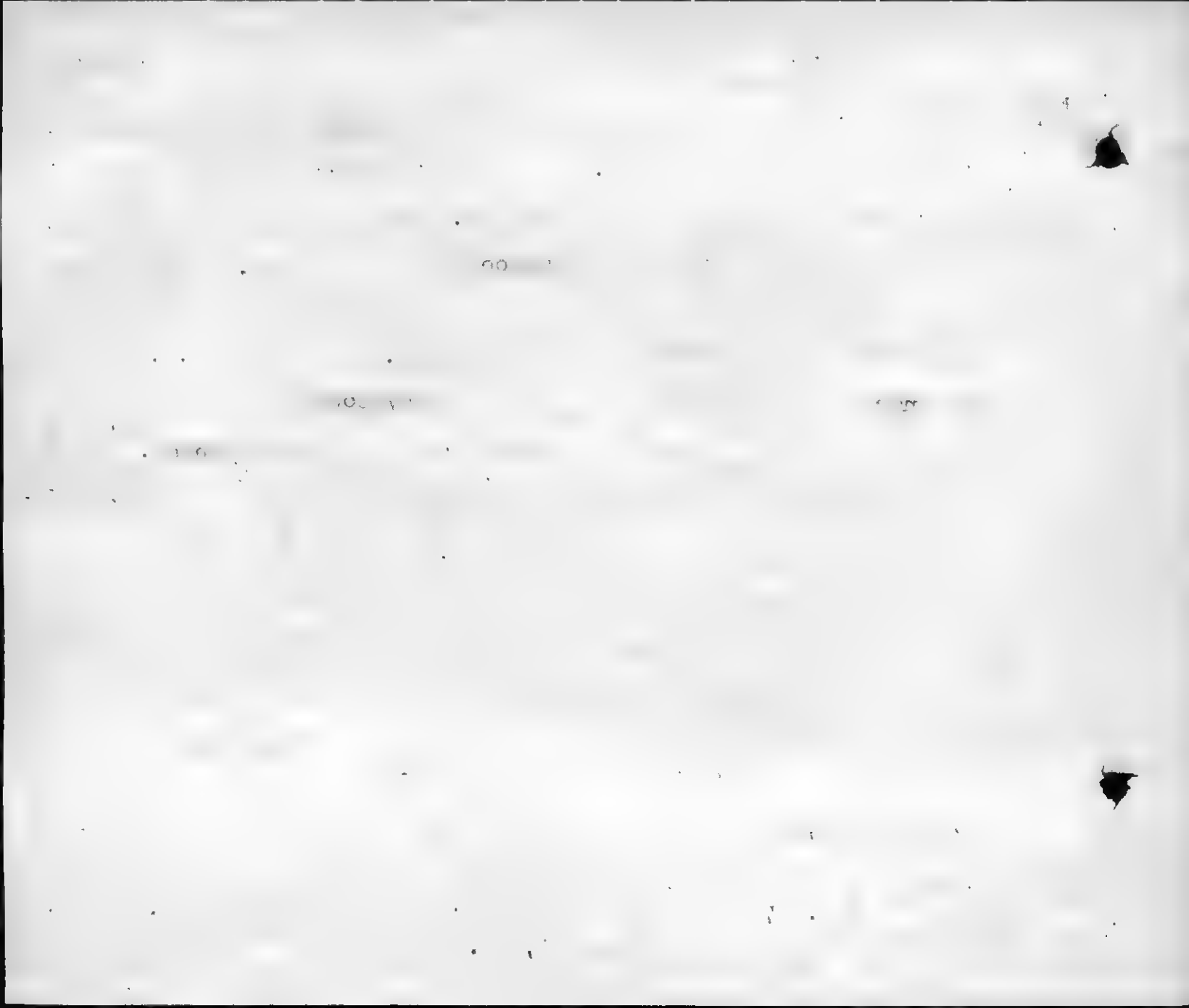


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02419 CERTIFICATE OF DEATH 02407

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport	
c. LENGTH OF STAY IN 1b 30 yrs.		d. STREET ADDRESS 106 S. Artizan Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 106 S Artizan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie Broadbuss Glascoe		4. DATE OF DEATH Feb. 14 19 62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH NOT KNOWN	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Luray Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Andrew Broadbuss		14. MOTHER'S MAIDEN NAME Lucy Sowers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none	
17. INFORMANT Jackey Broadbuss Princess Anne		Address Maryland RFD #1	
18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER). 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 2/14/62 to 2/14/62, 19... that (I) (we) last saw the deceased alive on 2/14/62, and that death occurred at 3 P.M. from the causes and on the date stated above. 22a. SIGNATURE Ralph Spring M.D. 22c. PHYSICIAN'S NAME (Type) Ralph Spring 22d. ADDRESS 22e. DATE SIGNED 2/15/62 22f. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Feb. 15-62 23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery 23d. LOCATION (City, town or county) Williamsport Md. (State) 24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf 25a. REC'D BY REGISTRAR DATE FEB 19 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hauer			



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MARYLAND STATE DEPARTMENT OF HEALTH

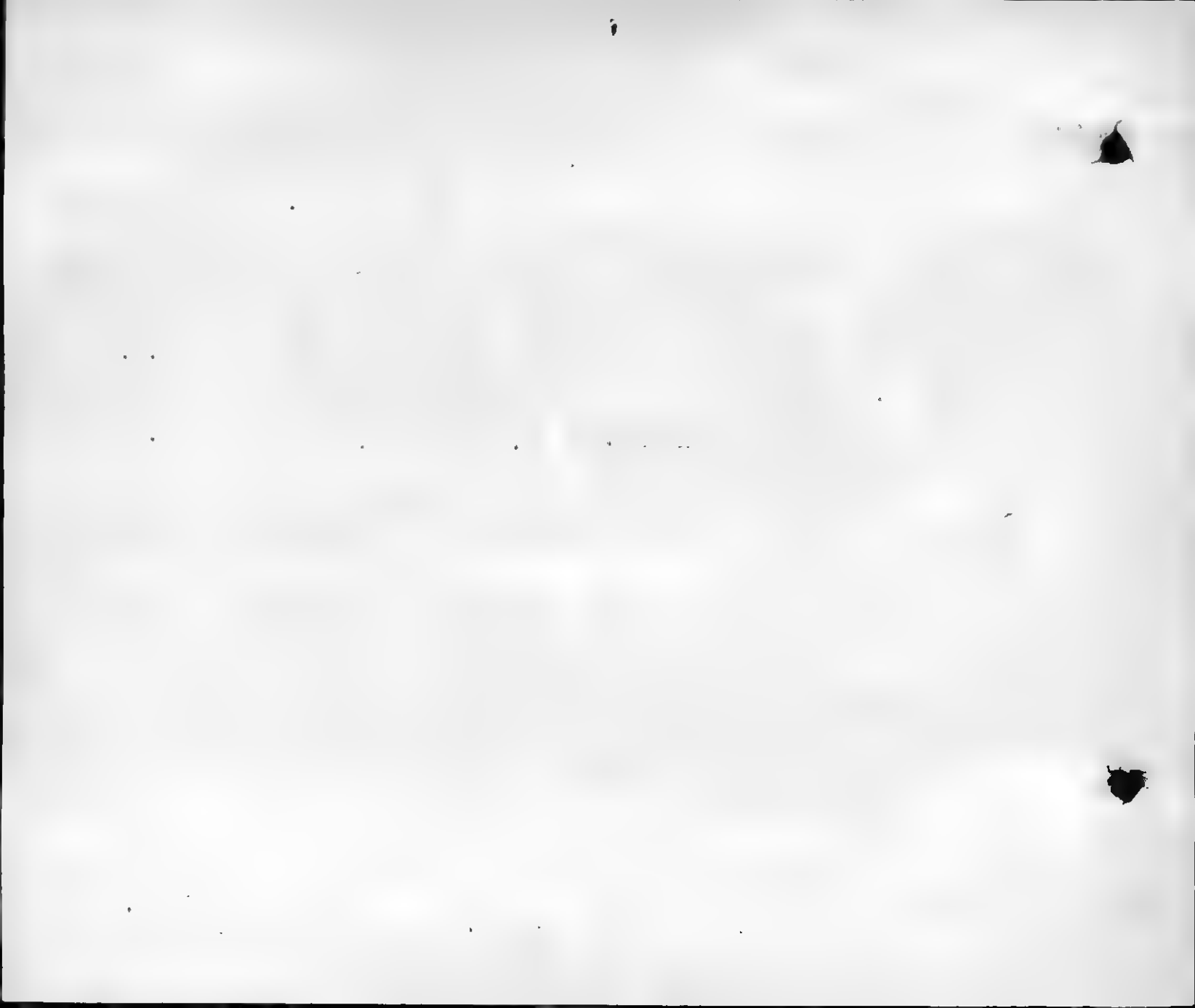
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02420

02408

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 11 Mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 415 GUILFORD AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MILDRED GAYNELL GOETZ		4. DATE OF DEATH Month FEBRUARY Day 12 Year 1962					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/1903	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 58 Days 58		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARRY C. SRINGIR		14. MOTHER'S MAIDEN NAME MINNIE PITTSNOGLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-16-4002		17. INFORMANT MR. WILLIAM P. GOETZ Address HAGERSTOWN ID.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Carcinoma DUE TO (b) with Generalized Metastasis DUE TO (c) 113 X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 6 mo. 2 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 11-25-58 to 2-12-62 that (I) (we) last saw the deceased alive on 2-12-62 and that death occurred at 2:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Charles F. Hess		22b. DATE SIGNED 2-14-62		22c. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.			
22d. ADDRESS Smithsburg Md		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/15/62		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.			
23d. LOCATION (City, town or county) HAGERSTOWN MD.		23e. (State) MD.					
24. FUNERAL DIRECTOR'S SIGNATURE W. F. Herment		24a. ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR FEB 16 '62			
25b. REGISTRAR'S SIGNATURE Arthur L. Jones							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

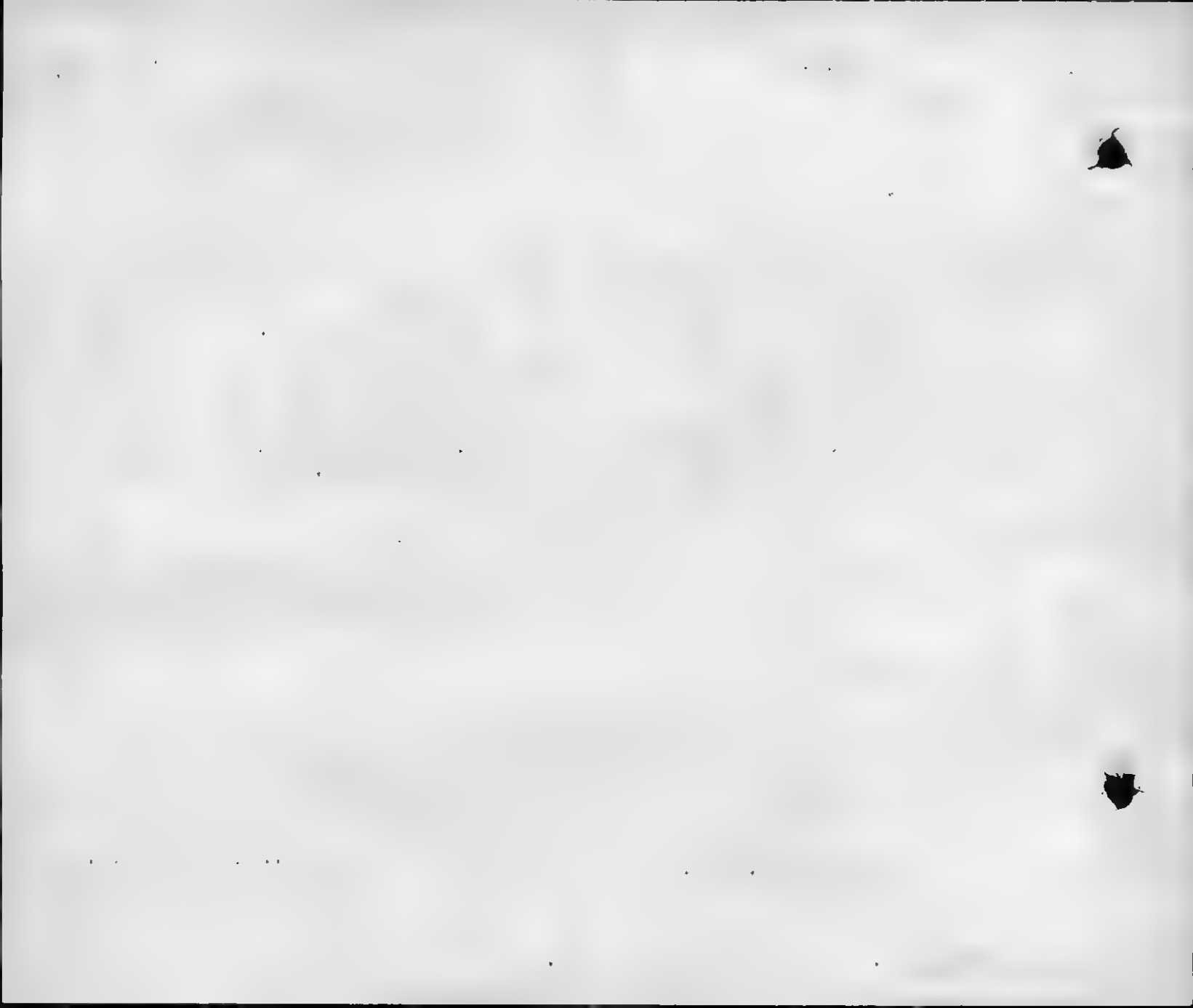
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02421

02409

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>2 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>360 Nottingham Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>418 Mitchell St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY MAGDALENE GOWER</u>		4. DATE OF DEATH <u>Feb 22 1962</u>		19 <u>19</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 17 1906</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md. Eakles Cross Rd Wash Co</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Montgomery</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Wade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-09-4416</u>		17. INFORMANT <u>Harry H. Gower</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Venous thrombosis</u> <u>Arteriosclerotic Heart disease</u> (b) <u>422.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Diabetes mellitus</u>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 9, 1957</u> to <u>Feb 22, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 21, 1962</u> , and that death occurred at <u>12 Noon</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Paul Harrison</u>		22b. DATE SIGNED <u>2/23/62</u>		22c. PHYSICIAN'S NAME (Type) <u>Paul Harrison, M. D.</u>	
22d. ADDRESS <u>318 N. Potomac St., Hagerstown, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>2/25/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			
23d. LOCATION (City, town or county) <u>Hagerstown Wash Co Md.</u>		23e. REC'D BY REGISTRAR			
23f. REGISTRAR'S SIGNATURE <u>Andrew K. Coffman</u>		DATE <u>FEB 26 '62</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

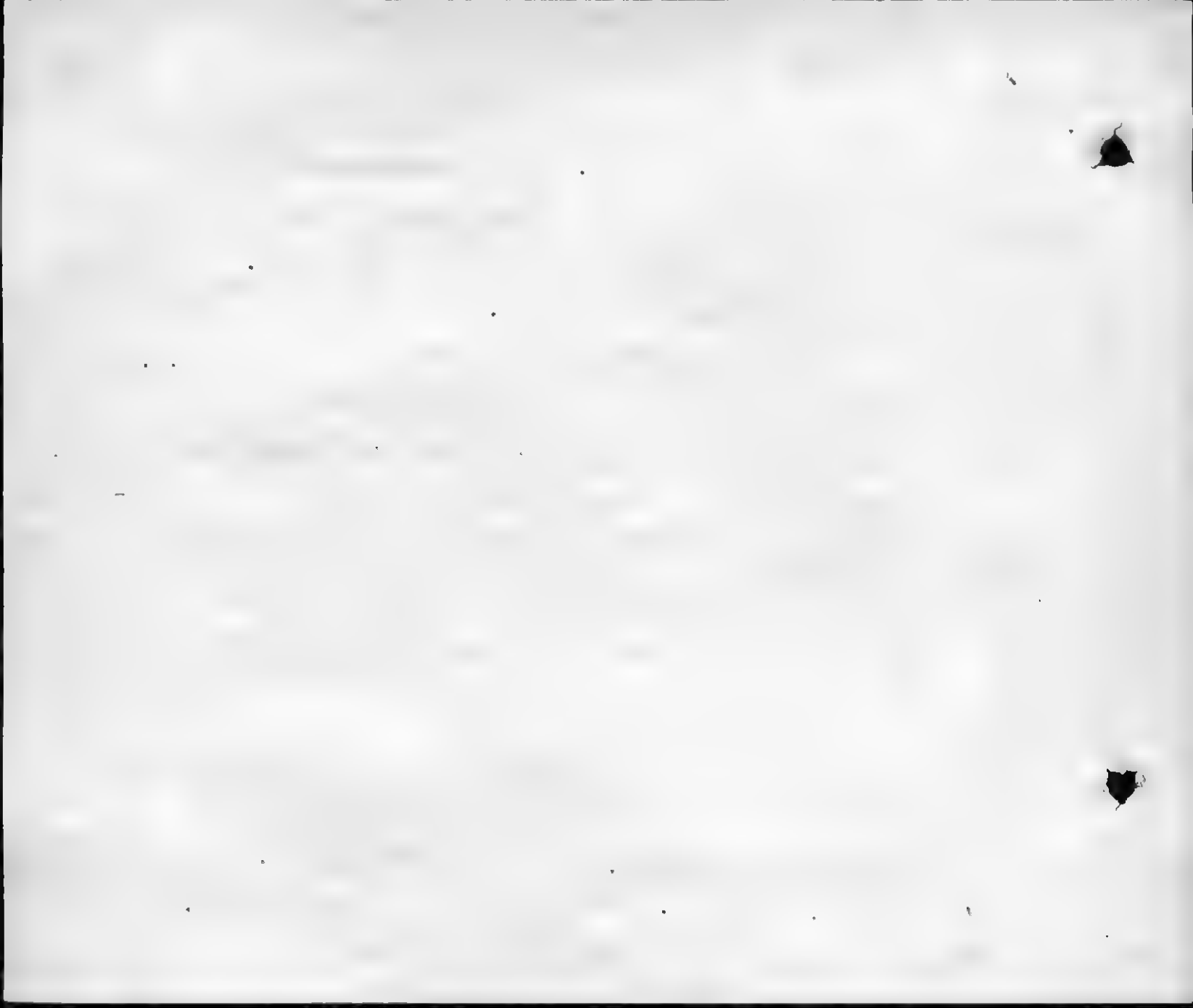
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02422

02110

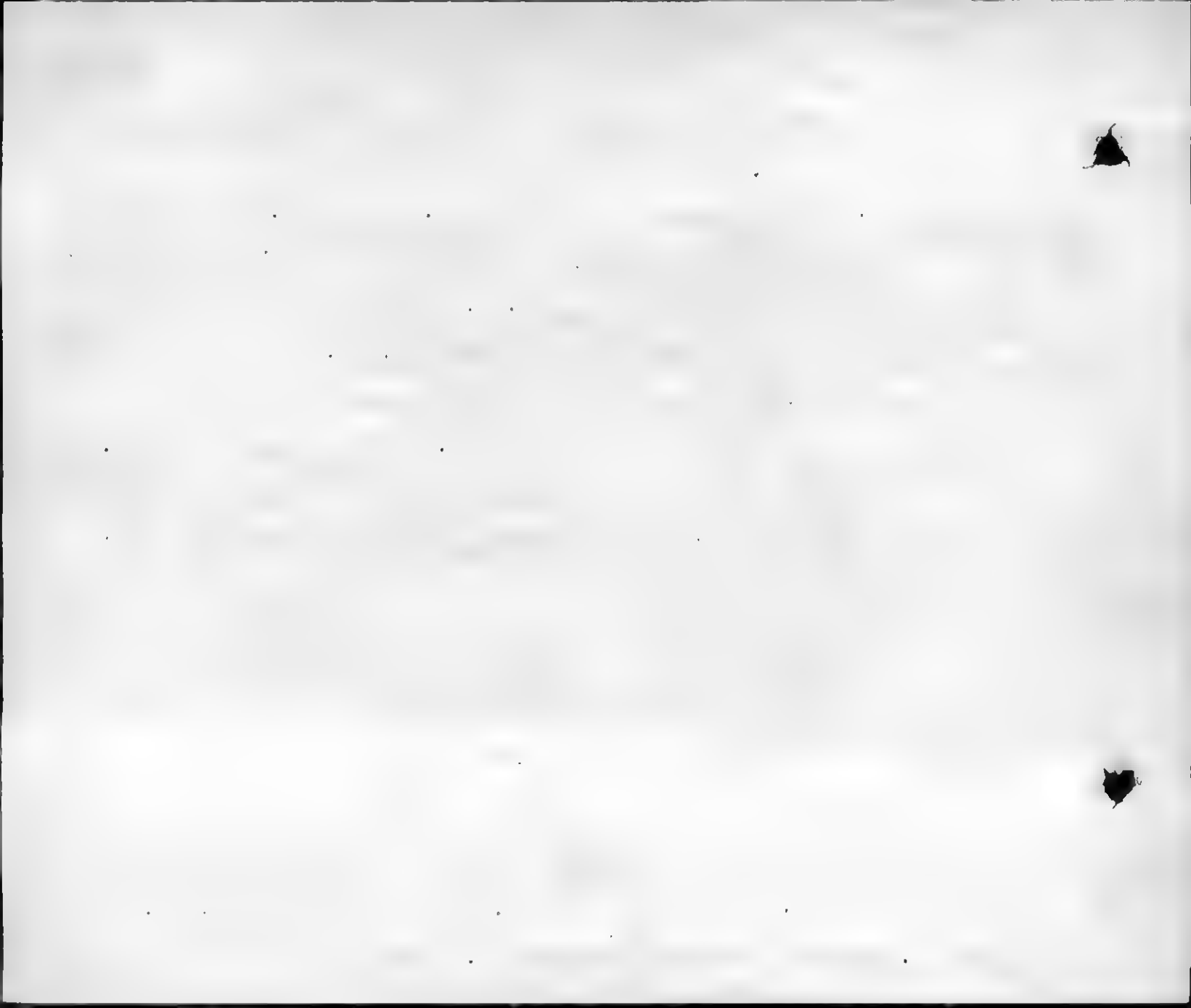
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Sharpsburg c. LENGTH OF STAY IN 1b 11 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sharpsburg RFD #1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Sharpsburg d. STREET ADDRESS Sharpsburg RFD #1 • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Daniel Gray		4. DATE OF DEATH Month Feb. Day 1 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 15 1908	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 1 Days 17	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Gray		14. MOTHER'S MAIDEN NAME Mammie Kretzer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-3640	
17. INFORMANT Mrs. Nellie Gray Sharpsburg Md RFD #1		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) Artherosclerotic cardio-vascular disease (a), stating the underlying cause last, (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?		INTERVAL BETWEEN ONSET AND DEATH 3-4 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from none to post mortem that (I) (we) last saw the deceased alive on 19 and that death occurred at 19 M, from the causes and on the date stated above.			
22a. SIGNATURE Walter H. Shealy M.D.		22b. DATE SIGNED Feb. 4, 1962	
22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M.D.		22d. ADDRESS Sharpsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 5-62	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town or county) (State) Sharpsburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Alfred L. Leaf Williamsport, Md		24. ADDRESS	
25a. REC'D BY REGISTRAR Feb 7 '62		25b. REGISTRAR'S SIGNATURE C. J. K. K.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
0.2423
CERTIFICATE OF DEATH
02411

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 35 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hospital		d. STREET ADDRESS 113 N. Locust St.	
3. NAME OF DECEASED (Type or print) Helen Elizabeth HADEN		4. DATE OF DEATH Month Day Year 2 - 9 - 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State or foreign country) Lynchburg, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Cornelious B. Tyree		14. MOTHER'S MAIDEN NAME Ada Sprouse	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-14-6368	
17. INFORMANT William E. Haden		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 170x DUE TO Abdominal Carcinomatosis Conditions, if any, which gave rise to immediate cause (b) Carcinoma of Breast, Left (c) DUE TO 10 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 months	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1961, to Feb. 9, 1962, that (I) (we) last saw the deceased alive on Feb. 9, 1962, and that death occurred at 8:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun M.D.		22b. DATE SIGNED Feb. 10, 1962	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-12-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Gardens		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR ADDRESS Hagerstown, Md. DATE FEB 13 '62	
		25b. REGISTRAR'S SIGNATURE	

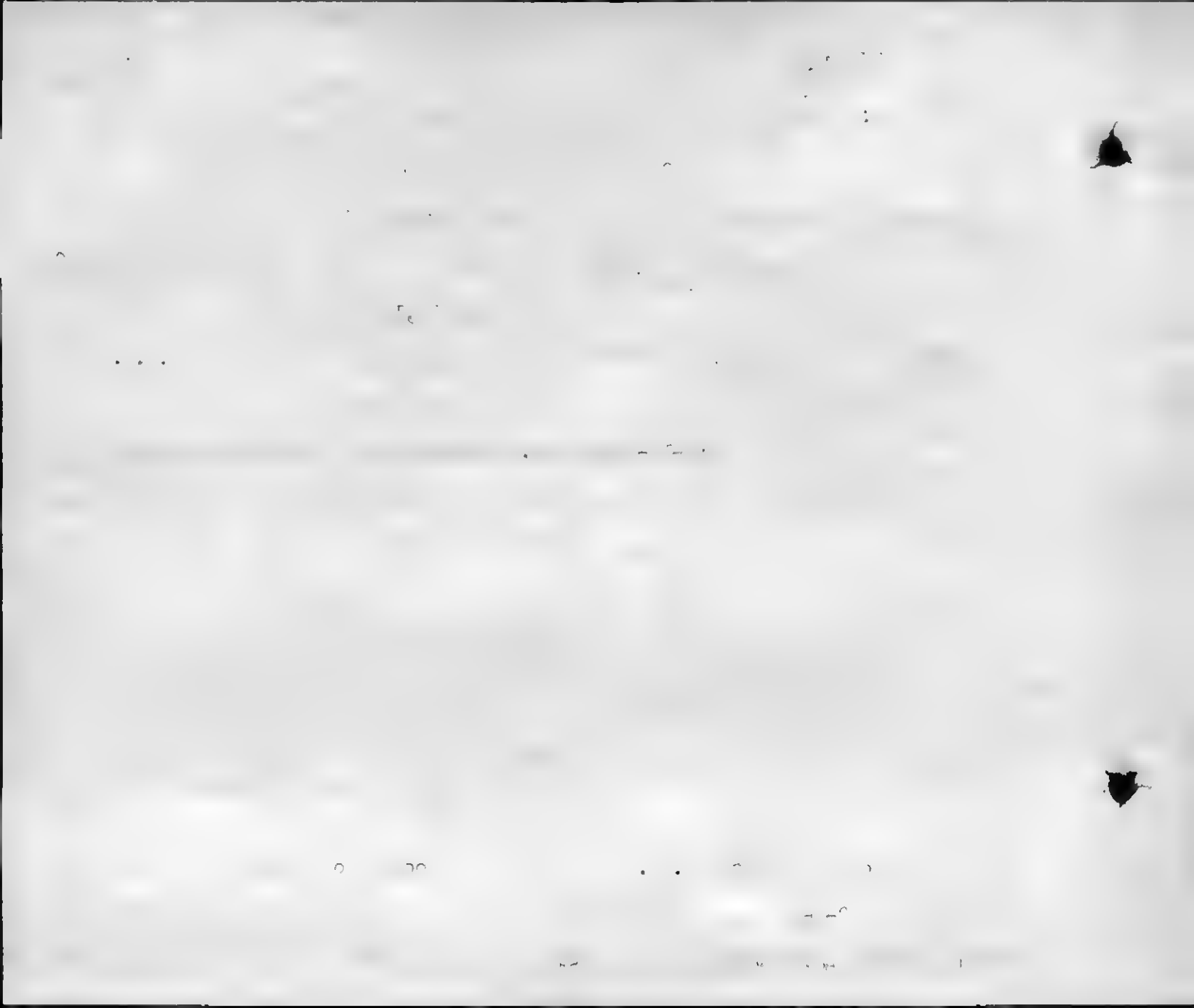


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02424
CERTIFICATE OF DEATH
02412

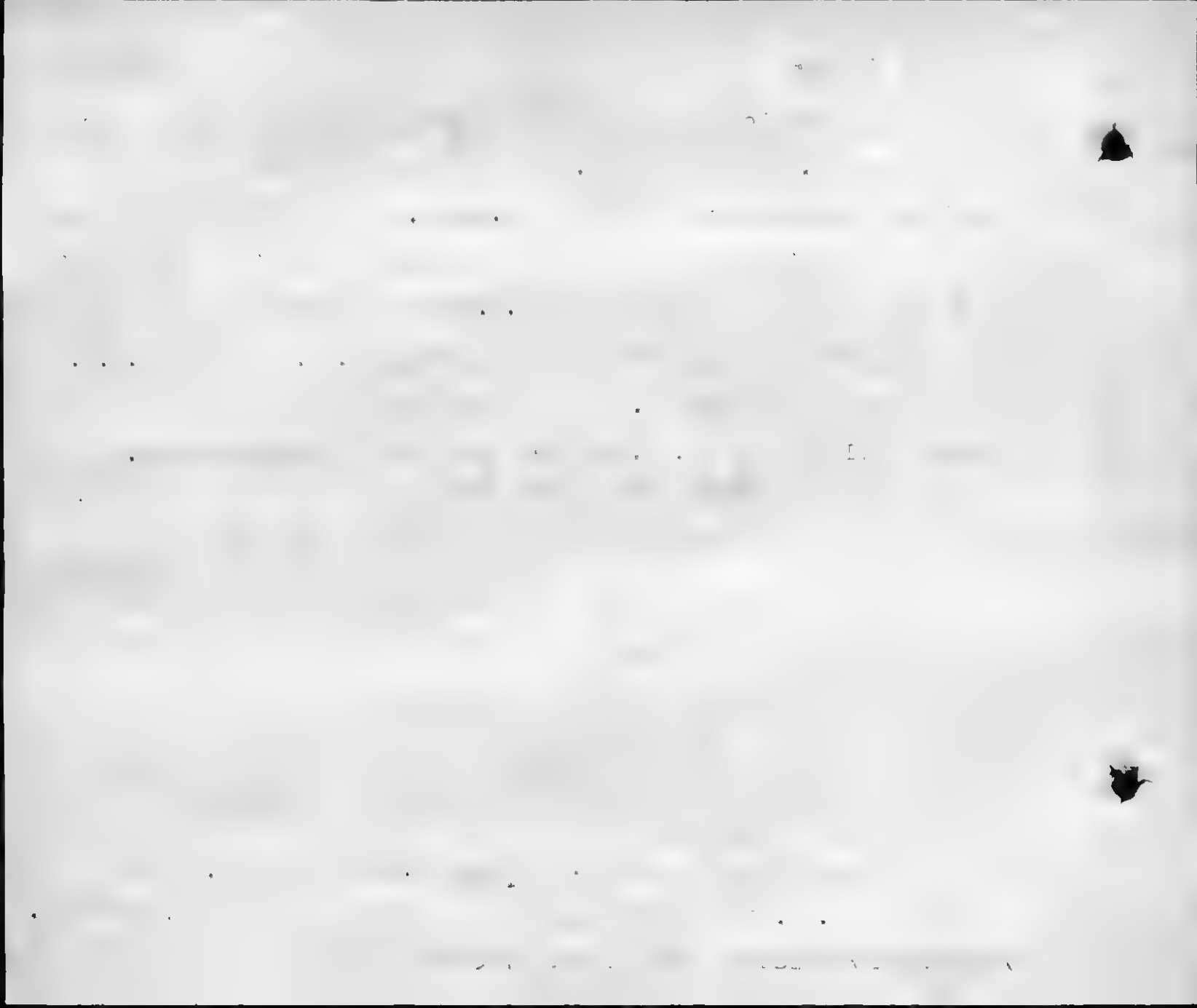
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO d. STREET ADDRESS 22 MAIN STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SPENCER THOMAS HALL 4. DATE OF DEATH FEBRUARY 1 19 62		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH JANUARY 18, 1893 9. AGE (In years IF UNDER 1 YEAR, last birthday) 69 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER 11. BIRTHPLACE ENGLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY HALL 14. MOTHER'S MAIDEN NAME KATHLEEN DUNN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 056-10-3982A 17. INFORMANT MRS. FLORENCE E HALL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) +20-1 DUE TO intercerebral with decompensation Conditions, if any, which gave rise to immediate cause (b) coronary thrombosis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a), (b), and (c).		INTERVAL BETWEEN ONSET AND DEATH 4 days 5 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 30, 1962 to Feb 1, 1962 , that (I) (we) last saw the deceased alive on January 31, 1962 , and that death occurred at 5 A.M. from the causes and on the date stated above.			
22a. SIGNATURE G. W. LeVan		22b. DATE SIGNED 2/1/62	
22c. PHYSICIAN'S NAME (Type) Gerald W LeVan M. D.		22d. ADDRESS Boonsboro Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION 23b. DATE THEREOF 2-3-62		23c. NAME OF CEMETERY OR CREMATORY GARDEN STATE CREMATORY 23d. LOCATION (City, town or county) (State) NORTH BERGEN NEW JERSEY	
24. FUNERAL DIRECTOR'S SIGNATURE Stephen Lyons for ADDRESS LYON'S FUNERAL HOME WESTWOOD NEW JERSEY		25a. REC'D BY REGISTRAR FEB 7 '62 25b. REGISTRAR'S SIGNATURE Chas. L. ...	



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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>															
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u> c. LENGTH OF STAY IN b. <u>7 1/2 Hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland</u> d. STREET ADDRESS <u>N. Penna.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Lafayette</u>		First Middle Last <u>Herbaugh Jr</u>		4. DATE OF DEATH Month Day Year <u>2 19 19 62</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4.6.1926</u>		9. AGE (In years last birthday) <u>35</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 2 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Moorefield W.VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lafayette Herbaugh Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Maude Foltz</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>235.32.6428</u>		17. INFORMANT <u>Mrs Nita K Herbaugh Hancock Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary occlusions old and recent</u> DUE TO (c) <u>Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 19, 1961</u> to <u>Feb 19, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 19, 1962</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>John C. Stauffer</u>				22b. DATE SIGNED <u>Feb 23 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>John C Stauffer 145 S. Prospect St. Hagerstown Md.</u>		22d. ADDRESS		22e. ATTENDING PHYS. <input type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2.21.62</u>		23c. NAME OF CEMETERY OR <u>Rest Haven</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Washington Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone</u>				25a. REC'D BY REGISTRAR <u>Hancock Md</u>		25b. REGISTRAR'S SIGNATURE <u>James S. House</u>		DATE <u>FEB 23 '62</u>							

VR A15 (4)
15M 9/60



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MARYLAND STATE DEPARTMENT OF HEALTH

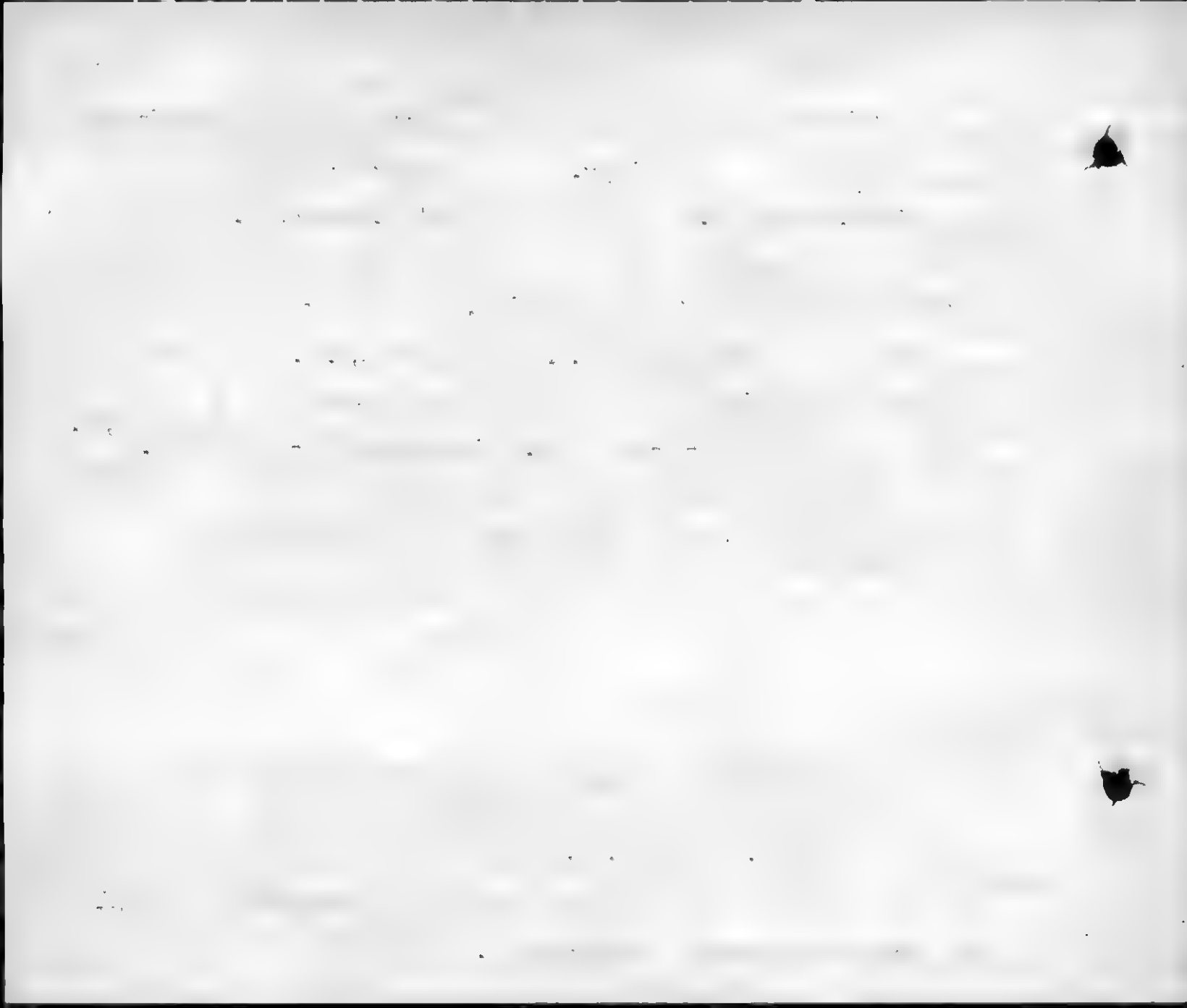
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02426

02414

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>37 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>310 N. Prospect St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>310 N. Prospect St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dewey</u> First Middle Last		4. DATE OF DEATH <u>February</u> <u>4</u> <u>1962</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1898</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania R.R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Martinsburg, W. Va.</u>	
13. FATHER'S NAME <u>Abram Haram</u>		14. MOTHER'S MAIDEN NAME <u>High</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-09-9401</u>		17. INFORMANT <u>Mrs. Doris Spoonire</u> Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19..., to <u>1962</u> , 19..., that (I) (we) last saw the deceased alive on <u>12/30</u> , 19 <u>61</u> , and that death occurred at <u>2P</u> M., from the causes and on the date stated above.					
22a. SIGNATURE <u>Howard N. Weeks, M.D.</u>		22b. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		22c. ADDRESS <u>136 N. Potomac Street</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/7/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
23d. LOCATION (City, town or county) <u>Hagerstown</u>		(State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Horst</u>		ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					



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MARYLAND STATE DEPARTMENT OF HEALTH

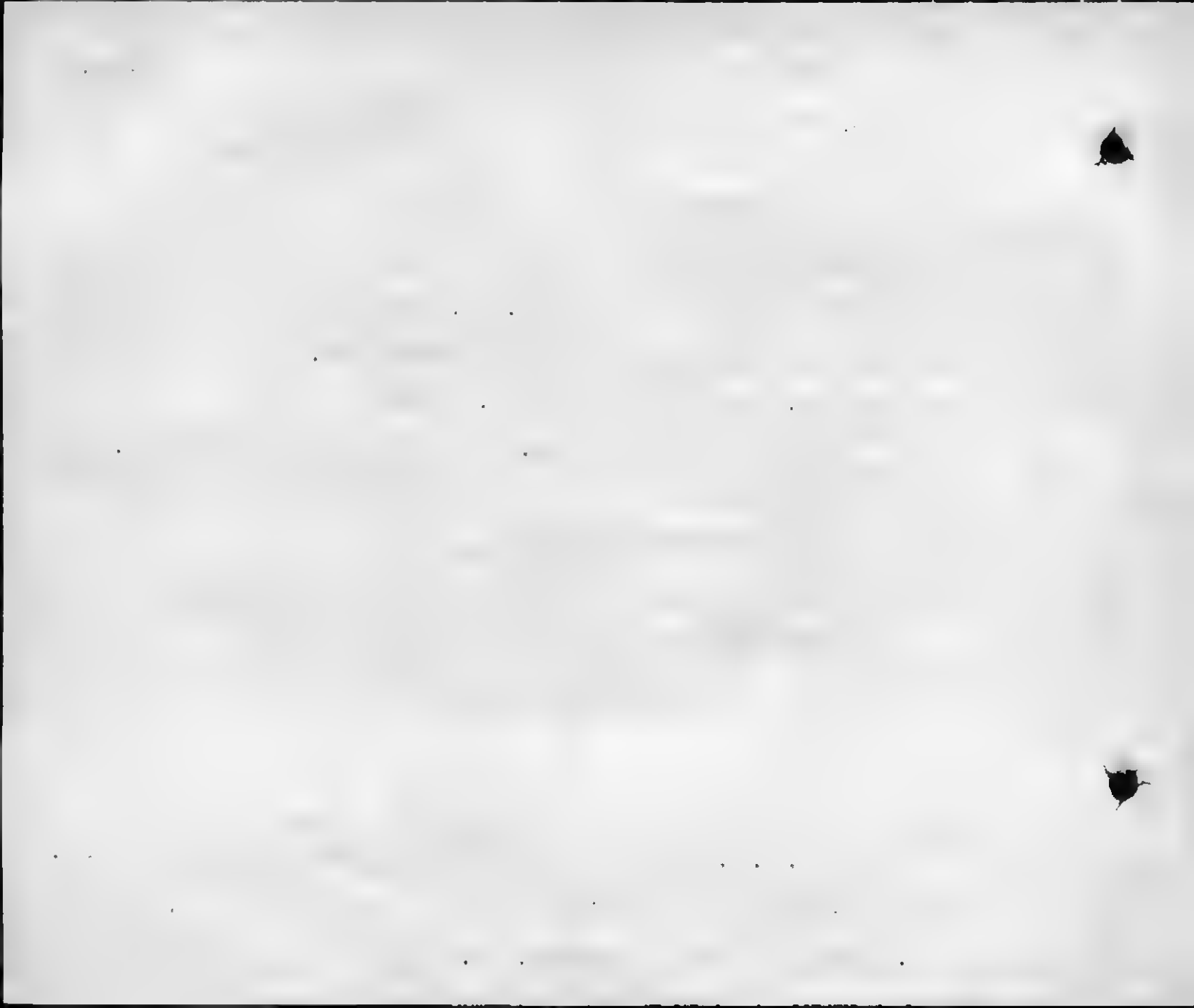
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02427

02415

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm'ssion) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Williamsport	
c. LENGTH OF STAY in 1b 2 weeks		d. STREET ADDRESS Route 2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Franklin Horn		4. DATE OF DEATH Month February Day 1 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Nov. 15, 1910	9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. 51 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store owner		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE Country & State or foreign country Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? C. Blanche Horn	
13. FATHER'S NAME William H. Horn		14. MOTHER'S MARDEN NAME Mrs. Ethel Horn Williamsport Rt. 2	
15. WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Gouty nephritis DUE TO (c) Gouty nephritis		INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric Ulcer		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1, 1962 to Feb 1, 1962 , that (I) (we) last saw the deceased alive on Feb 1, 1962 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. J. D. Wilson		22b. DATE SIGNED 2/2/62	
22c. PHYSICIAN'S NAME (Type) Dr. J. D. Wilson		22d. ADDRESS 135 North Potomac Street, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE FEB 6 '62	



02428

CERTIFICATE OF DEATH

Reg. Dist. 02416

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Dargan</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JESSE</u> Middle <u>HERMAN</u> Last <u>HOUSER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>19 02</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1880</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flagman (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Train Crew</u>	
11. BIRTHPLACE (State or foreign country) <u>Engle, West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Tilghman Houser</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jane Hanes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>705-14-0584</u>	
17. INFORMANT <u>Mrs. Elizabeth Houser</u>		18. RFD# <u>1, Harpers Ferry, West Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe epistaxis with shock</u> DUE TO (b) <u>Generalized arteriosclerosis</u> (c) <u>Pulmonary Abscess of R U Lobe.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>26 hours.</u> <u>5 Yrs.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema and Benign Prostatic hypertrophy.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u> </u> , to <u>2/27/62</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2/27/62</u> , 19 <u> </u> , and that death occurred at <u>3:10 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u> <u>Sharpsburg, Md.</u> <u>March 1, 1962</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/3/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Samples Manor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Samples Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald E. Epler</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '62</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02429

02117

1. PLACE OF DEATH a. COUNTY <u>Wash.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gateway Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution of residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rouzeville</u> d. STREET ADDRESS <u>Rouzeville, Pa.</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY E.</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/19/1880</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years IF UNDER 1 YEAR 11- UNDER 24 HRS. last birthday) Months Days Hours Min. <u>82</u>		4. DATE OF DEATH <u>Feb. 27, 1962</u> 10. OCCUPATION (Type and kind of work done during most of working life, even if retired) <u>Retired Farmer Farm</u> 11. PLACE OF BIRTH (County & State, or foreign country) <u>Franklin Co. Pa. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. B. Izer</u> 14. MOTHER'S MAIDEN NAME <u>Ida Swigert</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, if unknown) (If yes, give branch, dates of service) <u>160</u> 16. SOCIAL SECURITY NO. <u>210-26-5318</u> 17. INFORMANT <u>Clifford Izer</u> Address <u>224 Westside Ave Hagerstown, Md.</u>		18. CAUSE OF DEATH (Enter only one cause, but one for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <u>1 + 2 + 4</u> DUE TO <u>Acute Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Chronic Endocarditis</u> <u>Ch Acute Bronchial Asthma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Sudden</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 30, 1961</u> to <u>Feb 27, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 27, 1962</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>David R. Brewer</u> M.D. 22b. PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Clear Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>B.</u> (Specify) 23b. DATE THEREOF <u>3/1/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Waynesboro, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Munnich</u> ADDRESS <u>Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u>MAK</u> 5 '62 25b. REGISTRAR'S SIGNATURE <u>A. S. Jones</u>	

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

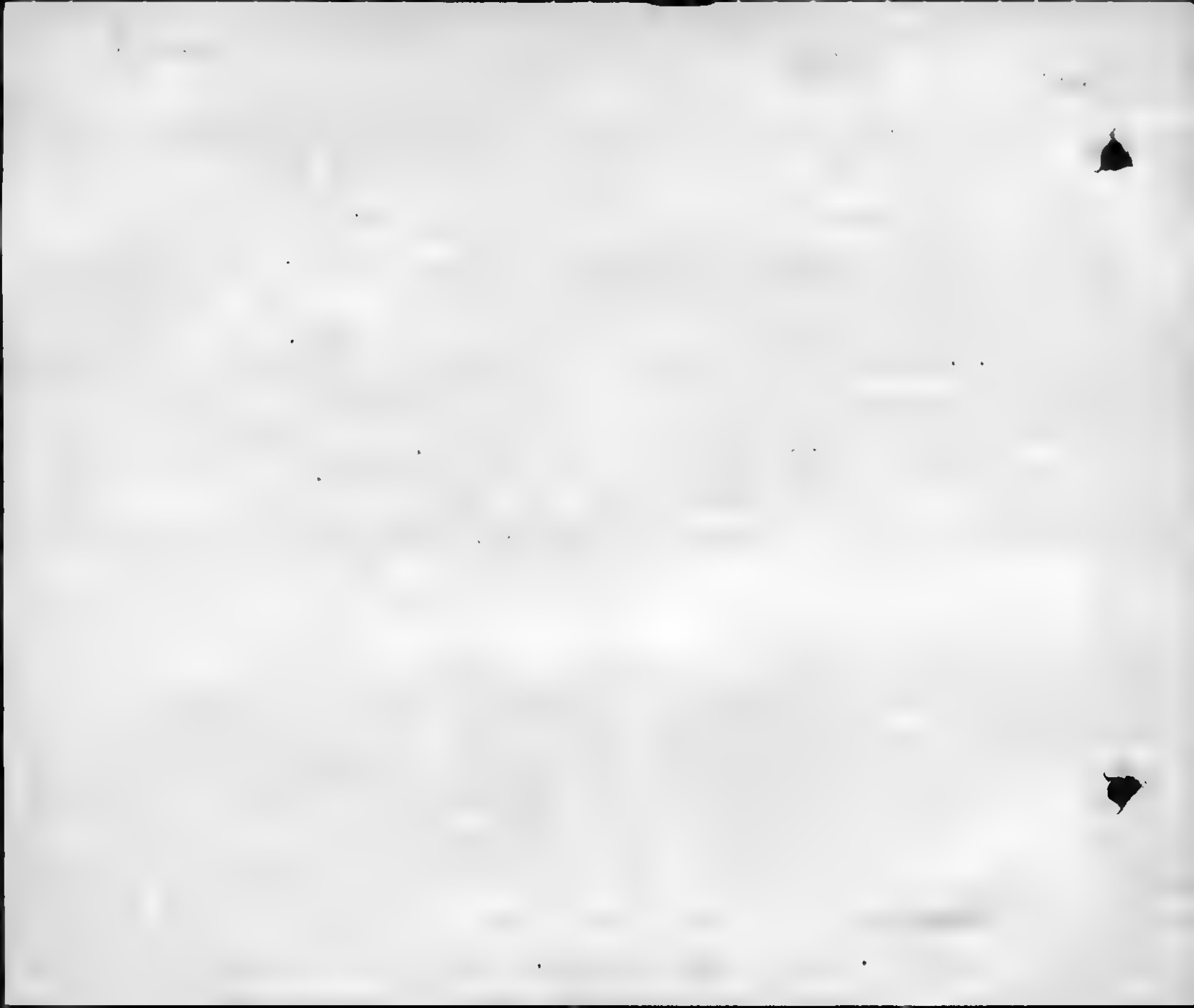
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02430

CERTIFICATE OF DEATH

02418

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 4 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 907 Mulberry Ave		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 907 Mulberry Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH MARSHALL JACKSON		4. DATE OF DEATH Last 1 4 DATE Month Feb Day 11 Year 1962		9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours M'n 78 yrs. 11 Months 11 Days 11 Hours 11 M'n	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. R. Machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE County & State or foreign country Harlansburg Mercer Co. PA.	
13. FATHER'S NAME Dr Homer Jackson		14. MOTHER'S MAIDEN NAME Alice Cross		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Rev Homer J. Jackson Address 907 Mulberry Ave Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic Cardiovascular Disease 5 yrs. DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-22-1962 to 2-11-1962 , that (I) (was) last saw the deceased alive on 2-10-1962 , and that death occurred at 8:05 PM , from the causes and on the date stated above.					
22a. SIGNATURE C. F. Hess		22b. DATE SIGNED 2-12-62		22c. PHYSICIAN'S NAME (Type) C. F. Hess	
22d. ADDRESS Smithsburg, Md		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. (City or town)	
22g. (County)		22h. (State)		22i. (City or town)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/15/62		23c. NAME OF CEMETERY OR CREMATORY Greendale Cemetery	
23d. LOCATION (City, town or county) Meadville Crawford Co Pa		23e. (State)		23f. (City or town)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24a. ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR FER 15 '62	
25b. REGISTRAR'S SIGNATURE C. F. Hess		25c. (City or town)		25d. (County)	
25e. (State)		25f. (City or town)		25g. (County)	
25h. (State)		25i. (City or town)		25j. (County)	
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25n. (State)		25o. (City or town)		25p. (County)	
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25bp. (State)		25bq. (City or town)		25br. (County)	
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25bx. (State)		25bx. (City or town)		25by. (County)	
25bz. (State)		25bz. (City or town)		25ca. (County)	
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25es. (State)		25es. (City or town)		25et. (County)	
25eu. (State)		25eu. (City or town)		25ev. (County)	
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25ey. (State)		25ey. (City or town)		25fz. (County)	
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25gk. (State)		25gk. (City or town)		25gl. (County)	
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25gw. (State)		25gw. (City or town)		25gx. (County)	
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25hu. (State)		25hu. (City or town)		25hv. (County)	
25hw. (State)		25hw. (City or town)		25hx. (County)	
25hy. (State)		25hy. (City or town)		25fz. (County)	
25ia. (State)		25ia. (City or town)		25ib. (County)	
25ic. (State)		25ic. (City or town)		25id. (County)	
25ie. (State)		25ie. (City or town)		25if. (County)	
25ig. (State)		25ig. (City or town)		25ih. (County)	
25ii. (State)		25ii. (City or town)		25ij. (County)	
25ik. (State)		25ik. (City or town)		25il. (County)	
25im. (State)		25im. (City or town)		25in. (County)	
25io. (State)		25io. (City or town)		25ip. (County)	
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25iu. (State)		25iu. (City or town)		25iv. (County)	
25iw. (State)		25iw. (City or town)		25ix. (County)	
25iy. (State)		25iy. (City or town)		25fz. (County)	
25ja. (State)		25ja. (City or town)		25jb. (County)	
25jc. (State)		25jc. (City or town)		25jd. (County)	
25je. (State)		25je. (City or town)		25jf. (County)	
25jg. (State)		25jg. (City or town)		25jh. (County)	
25ji. (State)		25ji. (City or town)		25jj. (County)	
25jk. (State)		25jk. (City or town)		25jl. (County)	
25jm. (State)		25jm. (City or town)		25jn. (County)	
25jo. (State)		25jo. (City or town)		25jp. (County)	
25jq. (State)		25jq. (City or town)		25jr. (County)	
25js. (State)		25js. (City or town)		25jt. (County)	
25ju. (State)		25ju. (City or town)		25jv. (County)	
25jw. (State)		25jw. (City or town)		25jx. (County)	
25jy. (State)		25jy. (City or town)		25fz. (County)	
25ka. (State)		25ka. (City or town)		25kb. (County)	
25kc. (State)		25kc. (City or town)		25kd. (County)	
25ke. (State)		25ke. (City or town)		25kf. (County)	
25kg. (State)		25kg. (City or town)		25kh. (County)	
25ki. (State)		25ki. (City or town)		25kj. (County)	
25kk. (State)		25kk. (City or town)		25kl. (County)	
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25ko. (State)		25ko. (City or town)		25kp. (County)	
25kq. (State)		25kq. (City or town)		25kr. (County)	
25ks. (State)		25ks. (City or town)		25kt. (County)	
25ku. (State)		25ku. (City or town)		25kv. (County)	
25kw. (State)		25kw. (City or town)		25kx. (County)	
25ky. (State)		25ky. (City or town)		25fz. (County)	
25la. (State)		25la. (City or town)		25lb. (County)	
25lc. (State)		25lc. (City or town)		25ld. (County)	
25le. (State)		25le. (City or town)		25lf. (County)	
25lg. (State)		25lg. (City or town)		25lh. (County)	
25li. (State)		25li. (City or town)		25lj. (County)	
25lk. (State)		25lk. (City or town)		25ll. (County)	
25lm. (State)		25lm. (City or town)		25ln. (County)	
25lo. (State)		25lo. (City or town)		25lp. (County)	
25lq. (State)		25lq. (City or town)		25lr. (County)	
25ls. (State)		25ls. (City or town)		25lt. (County)	
25lu. (State)		25lu. (City or town)		25lv. (County)	
25lw. (State)		25lw. (City or town)		25lx. (County)	
25ly. (State)		25ly. (City or town)		25fz. (County)	
25ma. (State)		25ma. (City or town)		25mb. (County)	
25mc. (State)		25mc. (City or town)		25md. (County)	
25me. (State)		25me. (City or town)		25mf. (County)	
25mg. (State)		25mg. (City or town)		25mh. (County)	
25mi. (State)		25mi. (City or town)		25mj. (County)	
25mk. (State)		25mk. (City or town)		25ml. (County)	
25mm. (State)		25mm. (City or town)		25mn. (County)	
25mo. (State)		25mo. (City or town)		25mp. (County)	
25mq. (State)		25mq. (City or town)		25mr. (County)	
25ms. (State)		25ms. (City or town)		25mt. (County)	
25mu. (State)		25mu. (City or town)		25mv. (County)	
25mw. (State)		25mw. (City or town)		25mx. (County)	
25my. (State)		25my. (City or town)		25fz. (County)	
25na. (State)		25na. (City or town)		25nb. (County)	
25nc. (State)		25nc. (City or town)		25nd. (County)	
25ne. (State)		25ne. (City or town)		25nf. (County)	
25ng. (State)		25ng. (City or town)		25nh. (County)	
25ni. (State)		25ni. (City or town)		25nj. (County)	
25nk. (State)		25nk. (City or town)		25nl. (County)	
25nm. (State)		25nm. (City or town)		25nn. (County)	
25no. (State)		25no. (City or town)		25np. (County)	
25nq. (State)		25nq. (City or town)		25nr. (County)	
25ns. (State)		25ns. (City or town)		25nt. (County)	
25nu. (State)		25nu. (City or town)		25nv. (County)	
25nw. (State)		25nw. (City or town)		25nx. (County)	
25ny. (State)		25ny. (City or town)		25fz. (County)	
25oa. (State)		25oa. (City or town)		25ob. (County)	
25oc. (State)		25oc. (City or town)		25od. (County)	
25oe. (State)		25oe. (City or town)		25of. (County)	
25og. (State)		25og. (City or town)		25oh. (County)	
25oi. (State)		25oi. (City or town)		25oj. (County)	
25ok. (State)		25ok. (City or town)		25ol. (County)	
25om. (State)		25om. (City or town)		25on. (County)	
25oo. (State)		25oo. (City or town)		25op. (County)	
25oq. (State)		25oq. (City or town)		25or. (County)	
25os. (State)		25os. (City or town)		25ot. (County)	
25ou. (State)		25ou. (City or town)		25ov. (County)	
25ow. (State)		25ow. (City or town)		25ox. (County)	
25oy. (State)		25oy. (City or town)		25fz. (County)	
25pa. (State)		25pa. (City or town)		25pb. (County)	
25pc. (State)		25pc. (City or town)		25pd. (County)	
25pe. (State)		25pe. (City or town)		25pf. (County)	
25pg. (State)		25pg. (City or town)		25ph. (County)	
25pi. (State)		25pi. (City or town)		25pj. (County)	
25pk. (State)		25pk. (City or town)		25pl. (County)	
25pm. (State)		25pm. (City or town)		25pn. (County)	
25po. (State)		25po. (City or town)		25pp. (County)	
25pq. (State)		25pq. (City or town)		25pr. (County)	
25ps. (State)		25ps. (City or town)		25pt. (County)	
25pu. (State)		25pu. (City or town)		25pv. (County)	
25pw. (State)		25pw. (City or town			



1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

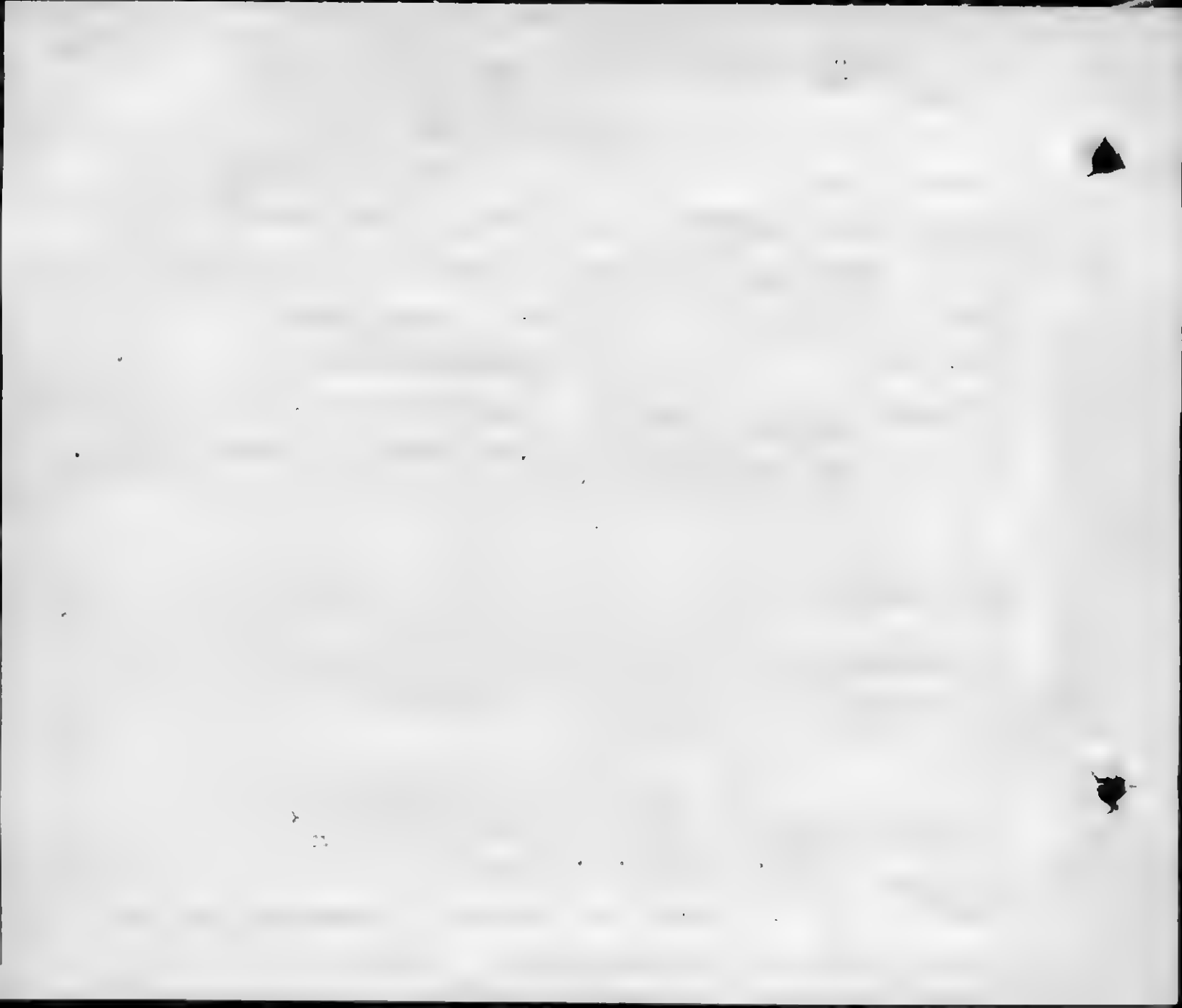
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02419

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md</u> c. LENGTH OF STAY IN <u>MARYLAND</u> <u>60 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>W Church Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> d. STREET ADDRESS <u>30 W Church Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Laura Bertha Jones</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 25 1899</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH <u>Feb 28 1962</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (State or foreign country) <u>Middletown Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Lane</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		14. MOTHER'S MAIDEN NAME <u>Catherine Fisher</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Mrs. Beatrice Davis Hagerstown, Md.</u> Address	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis & Thrombosis & malnutrition</u> Conditions, if any, which gave rise to immediate cause (b) <u>malnutrition</u> (c) <u>malnutrition</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of Item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D. EXAMINER'S NAME (Type) <u>Howard N. Weeks, M. D.</u> DATE SIGNED <u>3/2/62</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Mar 3 1962</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 22d. LOCATION (City, town, or country) <u>Hagerstown Md.</u> 22e. FUNERAL DIRECTOR <u>John R Watson Jr Hagerstown Md.</u> ADDRESS 24a. REC'D BY REGISTRAR <u>6 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Francis</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02432

02420

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>12 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PARK HALL RURAL</u> d. STREET ADDRESS <u>BOONSBORO MD. R. 2.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LUTHER M. JONES</u> 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u> 13. FATHER'S NAME <u>WILLIAM A. JONES</u>		4. DATE OF DEATH <u>FEBRUARY 27, 1962</u> 9. AGE (In years last birthday) <u>73</u> yrs. <u>11</u> months <u>23</u> days 11. BIRTHPLACE (County & State, or foreign country) <u>NEAR BOLIVER TOWN, FRED. CO. MD. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>218-38-1931</u> 17. INFORMANT <u>MRS. MARY JONES BOONSBORO MD. R. 2.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute gastro-enteritis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of the liver</u> (c), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 month.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 7, 1962</u> to <u>Feb. 27, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb. 26, 1962</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Walter H. Shealy</u> 22c. PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Chapensburg, Md.</u>	
22e. DATE SIGNED <u>2/28/62.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>MARCH 2, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY BOONSBORO WASH. CO. MD.</u> 23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baer</u> ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 5 '62</u> 25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

the funeral should be held within 72 hours after death

M

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02433					02421				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
a. COUNTY <u>Washington</u>					a. STATE <u>West Virginia</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>					b. COUNTY <u>Harpers Ferry</u>				
c. LENGTH OF STAY IN 1b <u>14 1/2 days</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) <u>Victoria Peach Jones</u>					4. DATE OF DEATH <u>February 27, 1962</u>				
5. SEX <u>Fe</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>May 29, 1890</u>				
9. AGE (In years last birthday) <u>71</u> yrs.					10. IF UNDER 1 YEAR Months Days				
11. IF UNDER 24 HRS. Hours Min.					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
13. FATHER'S NAME <u>James F. Cassell</u>					14. MOTHER'S MARDEN NAME <u>Peach Smith</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT <u>Mrs. William Reed - Harpers Ferry, W. VA</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450 c. Congestive failure</u>					3 days				
Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Atherosclerosis</u>					10 yrs				
(c) <u>none</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Anemia ② Viral gastroenteritis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year <u>19</u>					20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)					20f. (City or town, County) (State)				
21. I certify that (1) (this hospital) attended the deceased from <u>2/24</u> 19 <u>61</u> , to <u>2-26</u> 19 <u>62</u> , that (1) (we) last saw the deceased alive on <u>2-26</u> 19 <u>62</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>M.E. Byrkit</u>					22b. DATE SIGNED <u>2-27-62</u>				
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>					22d. ADDRESS <u>Williamsport Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE HEREOF <u>2/1/62</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>HARPER CEMETERY</u>					23d. LOCATION (City, town or county) (State) <u>HARPERS FERRY, W. VA.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Leary - 7444 Williamsport Md</u>					25a. REC'D BY REGISTRAR <u>FEB 28 '62</u>				
25b. REGISTRAR'S SIGNATURE <u>C. L. Smith</u>									

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

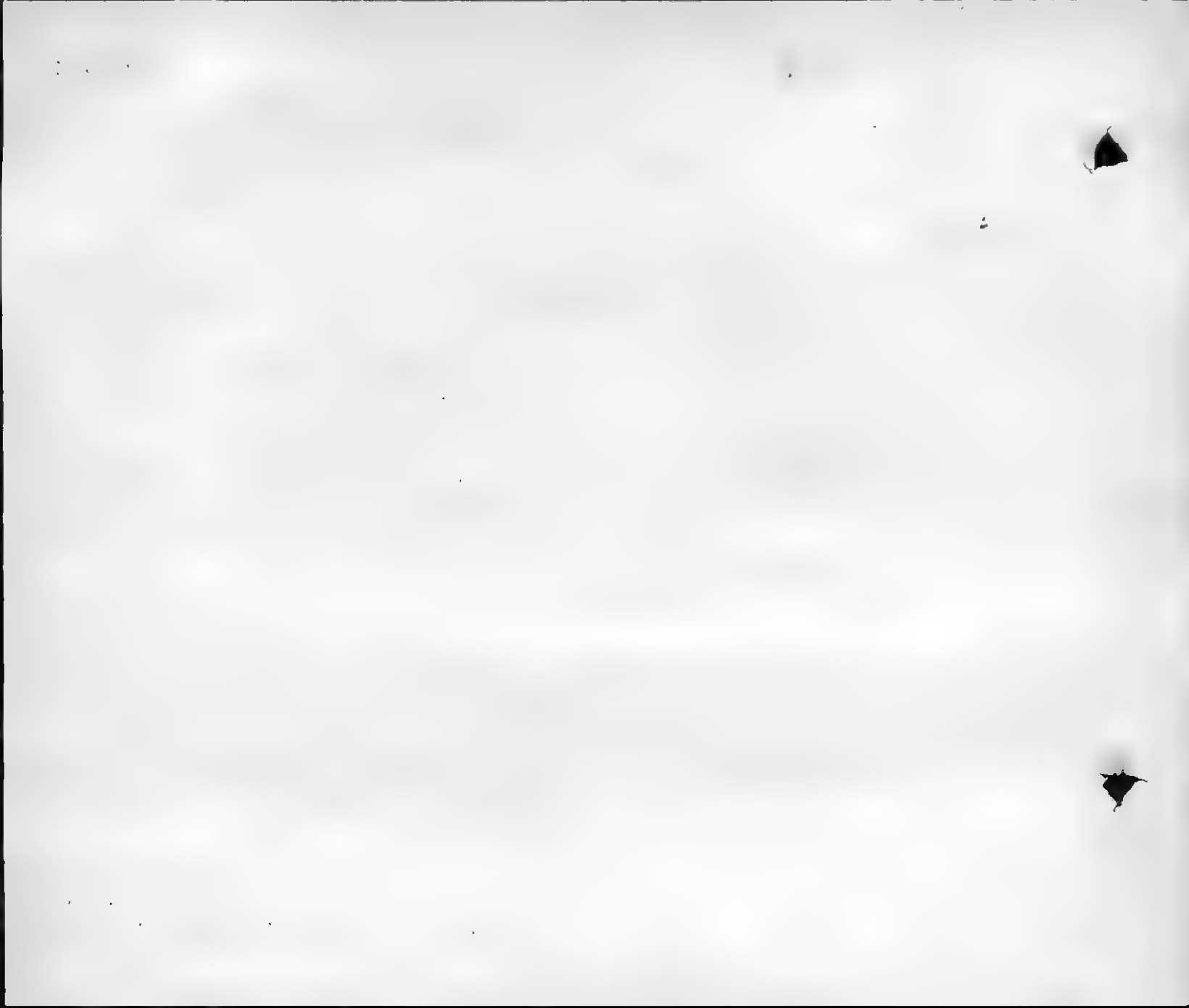
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02434

02122

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN 1b <u>SIX WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>REEDER NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>106 ST. PAUL ST.</u>		e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES MELVIN KLINE</u> 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF DEATH <u>FEBRUARY - 6 - 1962</u> 9. AGE (In years last birthday) <u>89</u> yrs. <u>2</u> Months <u>24</u> Days <u>5</u> Hours <u>10</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REFITTEE EMPLOYER ROAD DEPT.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>NEAR BOONSBORO WASH. Co. MD. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC KLINE</u> 14. MOTHER'S MAIDEN NAME <u>SUSAN MILLER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>220-09-9047</u> 17. INFORMANT <u>MRS PAUL L. STAUFFER</u> Address <u>BOONSBORO MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) <u>Generalized arteriosclerosis</u> (b) <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (c) <u>571.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>Feb 5 1962</u> 20d. INJURY OCCURRED While at work [] Not While at work [] 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Boonsboro, Md.</u> 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Feb 5 1962</u> to <u>Feb 6 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 5 1962</u> , and that death occurred at <u>2:17 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>G. W. Lelan</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>G. W. Lelan</u> 22d. ADDRESS <u>Boonsboro, Md.</u> 22e. REC'D BY REGISTRAR <u>Boonsboro, Md.</u> 22f. REGISTRAR'S SIGNATURE <u>Boonsboro, Md.</u> 22g. DATE SIGNED <u>2/7/62</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>FEBRUARY 9 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. Co. MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>BOONSBORO MD.</u> 25a. REC'D BY REGISTRAR <u>Boonsboro, Md.</u> 25b. REGISTRAR'S SIGNATURE <u>Boonsboro, Md.</u> 25c. DATE <u>FEB 13 '62</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02435 Items 5, 13 & 21 **CERTIFICATE OF DEATH** 4/2/62 iwk 02423

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN town 9 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1028 Mulberry Ave		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1028 Mulberry Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED Type or print! RUTH REID LEMEN		4. DATE OF DEATH Month Day Year Feb 19 1962 19		9. AGE (in years if under 1 year, if under 24 hrs., last birthday) Months Days Hours Min. 87 yrs	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 20 1874		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State) Waynesboro Franklin Co USA		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Reid	
14. MOTHER'S MAIDEN NAME Emma Amelia Snively		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Robert C. Porter		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 3 mos	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21	
20f. (City or town) Hagerstown		20g. (County) Md.		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Dec 19, 1961 to Feb 19, 1962 , that (I) (we) last saw the deceased alive on 2/17 , 19 62 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Robert V. H. Campbell		22b. DATE 2/21/62		22c. PHYSICIAN'S NAME (Type) Robert V. H. Campbell	
22d. ADDRESS Hagerstown Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/22/62		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town or county) Hagerstown Wash Co Md.		23e. (State) Md.		23f. REC'D BY REGISTRAR FEB 23 '62	
23g. REGISTRAR'S SIGNATURE Andrew K. Coffman		23h. HAGERSTOWN Md.		23i. REGISTRAR'S SIGNATURE Andrew K. Coffman	

VR A15 (4)
15M 9/68



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

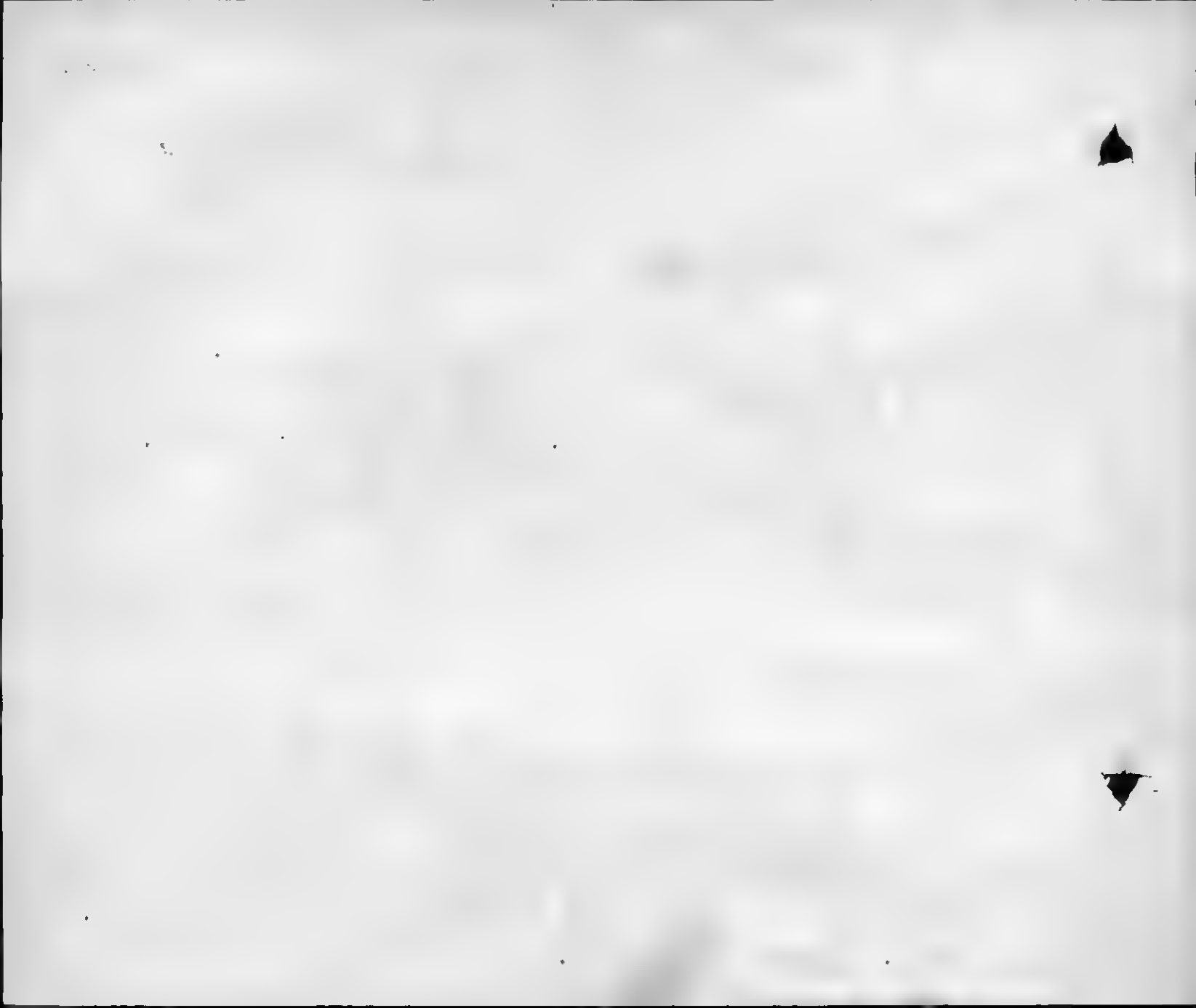
02436

02121

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 6</u> c. LENGTH OF STAY N 1b <u>55 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cearfoss Pike</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 6</u> d. STREET ADDRESS <u>Cearfoss Pike</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARA</u> First Middle Last 4. DATE OF DEATH <u>Feby 3 1962</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 27 1870</u> last birthday Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. 8TH PLACE County & State, or foreign country <u>Hagerstown Wash Co Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Calvin Foltz</u> 14. MOTHER'S MAIDEN NAME <u>Annie Miller</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO <u>None</u> 17. INFORMANT <u>M. Kenneth Long</u> Address <u>Hagerstown Md. R # 6</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cerebrovascular Disease</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20f. (City or town) <u>Hagerstown</u> (County) <u>Washington</u> (State) <u>Md.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>6-1-1938</u> to <u>3-3-62</u> , that (I) (we) last saw the deceased alive on <u>2-3-62</u> , and that death occurred <u>5 P.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>A. K. Coffman</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. H. T. To J.</u>		22b. DATE SIGNED 22d. ADDRESS ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>Hagerstown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/6/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u> 23d. LOCATION (City, town or county) <u>Hagerstown Wash Co Md.</u> (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u> 25a. REC'D BY REGISTRAR <u>FEB 8 '62</u> 25b. REGISTRAR'S SIGNATURE <u>L. H. H.</u>	

VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02425

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN b 10 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 922 POPE AVENUE		d. STREET ADDRESS 922 POPE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE ALICE LONG		4. DATE DEATH		Month Day Year FEBRUARY 18 1962	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH MARCH 5 1892		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARTINSBURG WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES V MASON		14. MOTHER'S MAIDEN NAME MARY J FRANKS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 215-34-4077		17. INFORMANT MRS WINIFRED SNAVELY HAGERSTOWN MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic Vascular Disease DUE TO (c) Self down stairs at time of fall		INTERVAL BETWEEN ONSET AND DEATH 6 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Self down stairs at time of fall		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)		20c. TIME OF INJURY Month, Day, Year 2-18-62	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, store, office, etc.) Home		20f. (City or town) (County) (State) Hagerstown W. Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-18-62	
ACTUAL EXAMINER'S NAME (Type) E.W. DITTO JR. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-21-62		22c. NAME OF CEMETERY OR CREMATORY ROSEDALE CEMETERY	
22d. LOCATION (City, town, or country) (State) MARTINSBURG WEST VIRGINIA		23. FUNERAL DIRECTOR SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND		24a. REC'D BY REGISTRAR DATE FEB 26 '62	
24b. REGISTRAR'S SIGNATURE <i>Walter S. Brown</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02438

02126

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>1yr-5mo-24days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium Inc.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1118 Oak Hill, Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Louise</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <u>Feb. 12, 1962</u> 9. AGE (In years last birthday) <u>77</u> yrs. 10. BIRTHPLACE (County & State, or foreign country) <u>Chicago, Illinois</u> 11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>School</u> 13. FATHER'S NAME <u>William Weiss</u> 14. MOTHER'S MAIDEN NAME <u>Louise Vollman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Mrs. HARVEY H. HAYSER Jr.</u> Address <u>HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis - General</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u> 20c. TIME OF INJURY Month, Day, Year <u>March 1962</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Hagerstown Maryland</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1962</u> to <u>Feb. 12, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 12, 1962</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffman</u> 22c. PHYSICIAN'S NAME (Type) <u>LYOYD A. HOFFMAN M. D.</u>		22b. DATE SIGNED <u>Feb. 13-62</u> 22d. ADDRESS <u>214 N. POTOMAC ST. HAGERSTOWN MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-14-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR LAWN MEMORIAL GARDENS</u> 23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MARYLAND</u>		25a. REC'D BY REGISTRAR <u>Feb 19 '62</u> 25b. REGISTRAR'S SIGNATURE <u>C. L. S. Thomas</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please use the word "pending" in pencil in Item 18. G. ve Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		MARYLAND		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		HAGERSTOWN		c. LENGTH OF STAY IN TB		1 DAY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		COLMAR MANOR	
d. NAME OF HOSPITAL, OR INSTITUTION (if not in hospital, give street address)		WESTERN MD. STATE HOSPITAL		d. STREET ADDRESS		3427 40TH PLACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		MARY JULIA MADDOX		4. DATE OF DEATH		Feb. 28 1962		5. SEX		F	
6. COLOR OR RACE		W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		DOMESTIC		11. BIRTHPLACE (State or foreign country)		VIRGINIA	
13. FATHER'S NAME		JOHN MADDOX		14. MOTHER'S MAIDEN NAME		MARY MADDOX		12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT		Address	
								MRS. JULIA TRICK, COLMAR MANOR, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		MURDER		INTERVAL BETWEEN ONSET AND DEATH		10 days			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		DUE TO		Circumstances of death		5 mo					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Arteriosclerotic cardiovascular disease									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Self while walking at home							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		9-61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		Home		20f. (City or town) (County) (State)	
								Colmar Manor Prince Georges		MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EW Dittig		CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type)		Dr. E. W. Dittig		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						3/28/62	
				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)					
BURIAL		3-3-62		PROSPECT HILL		FRONT ROYAL VA.					
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
MADDOX FUNERAL HOME - FRONT ROYAL, VA.				MAR 5 '62							
(CRM for)											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02440

02428

1. PLACE OF DEATH
a. COUNTY Wash. b. CITY OR TOWN (if outside corporate limits, give RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b — d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash. Co. Hospital

2. USUAL RESIDENCE (Where deceased lived at institution; Residence before admission)
a. STATE Maryland b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS Wash. Co. Hospital

3. NAME OF DECEASED (Type or print) Baby Boy 4. DATE OF DEATH Feb. 20 1962

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 2/19/62 9. AGE (In years: If UNDER 1 YEAR, last birthday) | Months | Days | Hours | Min. 4

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE County & State or foreign country Hagerstown, md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harold Martin 14. MOTHER'S MAIDEN NAME Vivian Kendall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) no 16. SOCIAL SECURITY NO None 17. INFORMATION Harold Martin - 207 Lincoln Ave Hagerstown md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hydncephalus
751.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spine fracture
DUE TO (c) St. infection

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/19 1962, to 2/20 1962, that (I) (we) last saw the deceased alive on 2/19 1962, and that death occurred at 2:45 PM, from the causes and on the date stated above.

22a. SIGNATURE E. H. Hockler M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 2/20/62

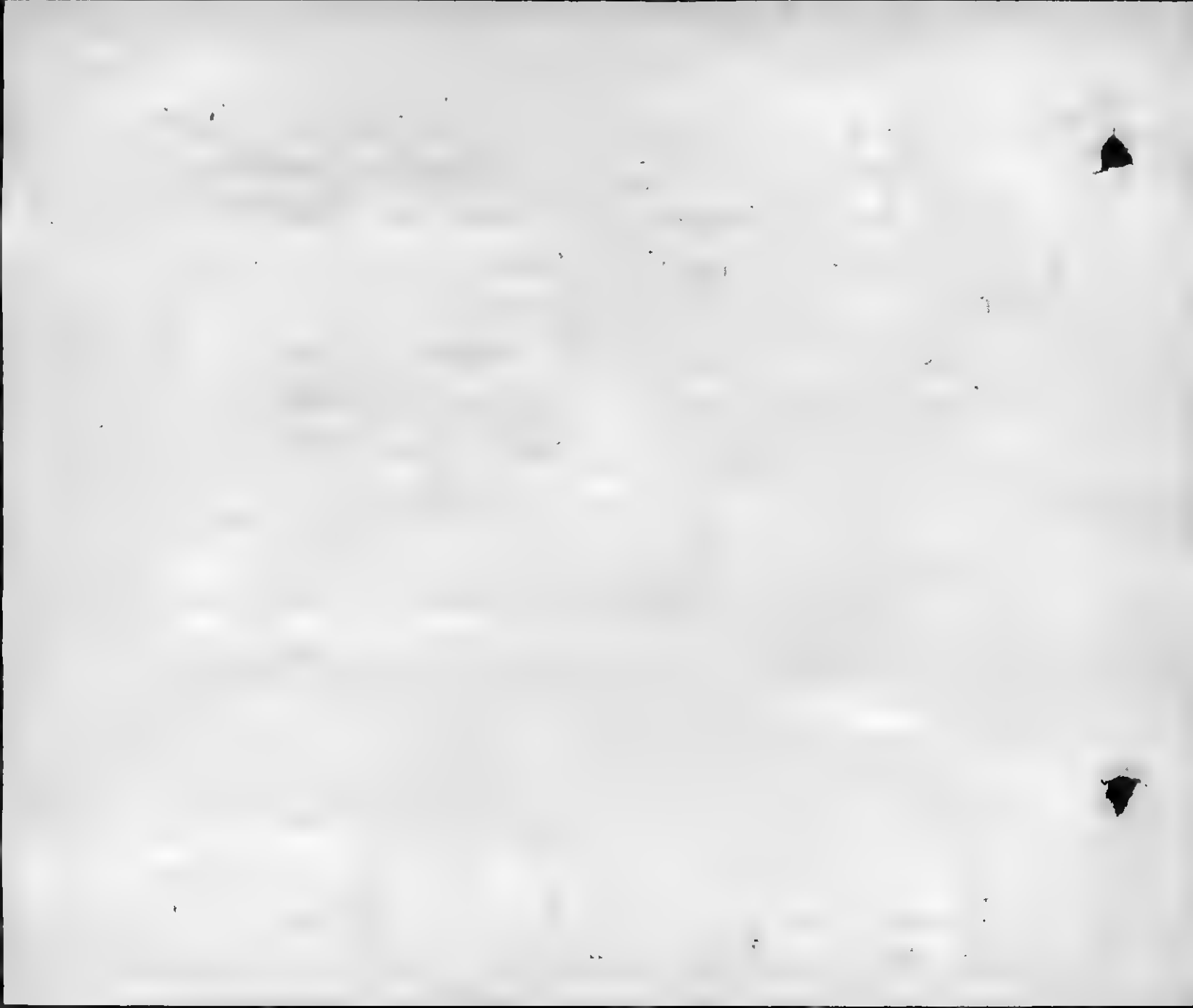
22c. PHYSICIAN'S NAME (Type) E. H. Hockler 22d. ADDRESS Hagerstown Md.

23a. FUNERAL, CREMATION, OR BURIAL (Specify) Burial 23b. DATE THEREOF 2/21/62 23c. NAME OF CEMETERY OR CREMATORY Ringgold Cem. 23d. LOCATION (City, town or county) (State) Ringgold, Md.

24. FUNERAL DIRECTOR'S SIGNATURE A. E. Munnich ADDRESS Greencastle, Pa. 25a. REC'D BY REG. STAFF — 25b. REGISTRAR'S SIGNATURE Clifford S. Harris

DATE FEB 23 '62

2-602531



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02441

02129

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 823 1/2 Pine St		3. NAME OF DECEASED (Type or print) Unnamed Baby Girl		4. DATE OF DEATH Month Feb Day 14 Year 1962		5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> xx		8. DATE OF BIRTH Feb 14 1962		9. AGE (In years if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) Months Days Hours Min. 1		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert C. Martin Jr.		14. MOTHER'S MAIDEN NAME Helen D. Summers		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Robert C. Martin Jr.		18. ADDRESS 823 1/2 Pine St Hagerstown Md.		19. INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 6 days		20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intant cause pneumonia DUE TO 763.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Premature rupture of membranes DUE TO (c) Prematurity		21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity		22. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 14 Feb 1962		21. I certify that (I) (this hospital) attended the deceased from 14 Feb 1962 to 14 Feb 1962 , that (I) (we) last saw the deceased alive on 14 Feb 1962 , and that death occurred at 2 PM , from the causes and on the date stated above.		22a. SIGNATURE Harold H. Gist		22b. DATE SIGNED 16 Feb 1962		22c. PHYSICIAN'S NAME (Type) Harold H. Gist		22d. ADDRESS 111 N. Potomac St., Hagerstown, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE 16 Feb 1962									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/62		23c. NAME OF CEMETERY OR CREMATORY Luthern Cemetery		23d. LOCATION (City, town or county) (State) Leitersburg Wash Co Md.		24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		25a. REC'D BY REGISTRAR DATE FEB 20 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH

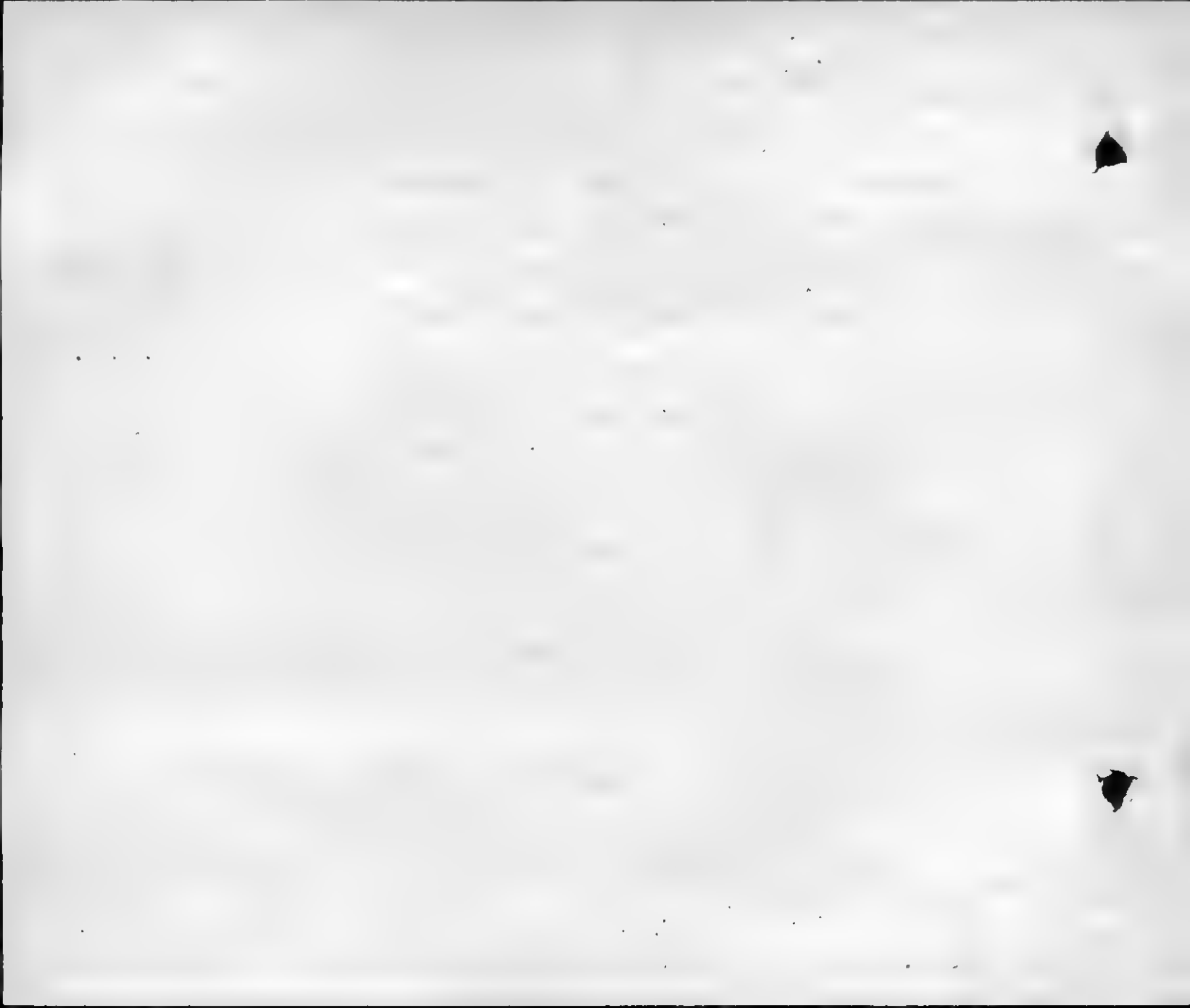
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02442

02150

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN <u>2 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> Allegany f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town, <u>Cumberland</u> g. STREET ADDRESS <u>317 Columbia Street</u>	
3. NAME OF DECEASED (Type or print) <u>ARCHIE SCOTT MARVIN</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>October 4, 1913</u> 9. AGE (In years last birthday) <u>48</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painting Contractor</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Scott Marvin</u> 14. MOTHER'S MAIDEN NAME <u>Laura Middleton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>214-07-5222</u> 17. INFORMANT <u>Mrs. Ida Benzel</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobular pneumonia, bilateral</u> Conditions, if any, which gave rise to immediate cause (b) <u>carcinoma of mouth & local metastasis</u> cause last. (c) <u>1 year</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) <u>6 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>14-1-X</u>			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1500 Pa Ave Hagerstown Md.</u> 20f. (City or town) <u>Cumberland</u> (County) <u>Maryland</u> (State) <u>Maryland</u>			
21. I certify that (I) (this) (we) attended the deceased from <u>2-14-1962</u> to <u>2-28-1962</u> that (I) (we) last saw the deceased alive on <u>2-28-1962</u> and that death occurred at <u>11:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u> 22b. DATE SIGNED <u>2-28-1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. Ramos, M.D.</u> 22d. ADDRESS <u>1500 Pa Ave Hagerstown Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/3/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u> 23d. LOCATION (City, town or county) <u>Cumberland</u> (State) <u>Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u> 25a. REC'D BY REGISTRAR <u>MAR 5 '62</u> 25b. REGISTRAR'S SIGNATURE <u>1088</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

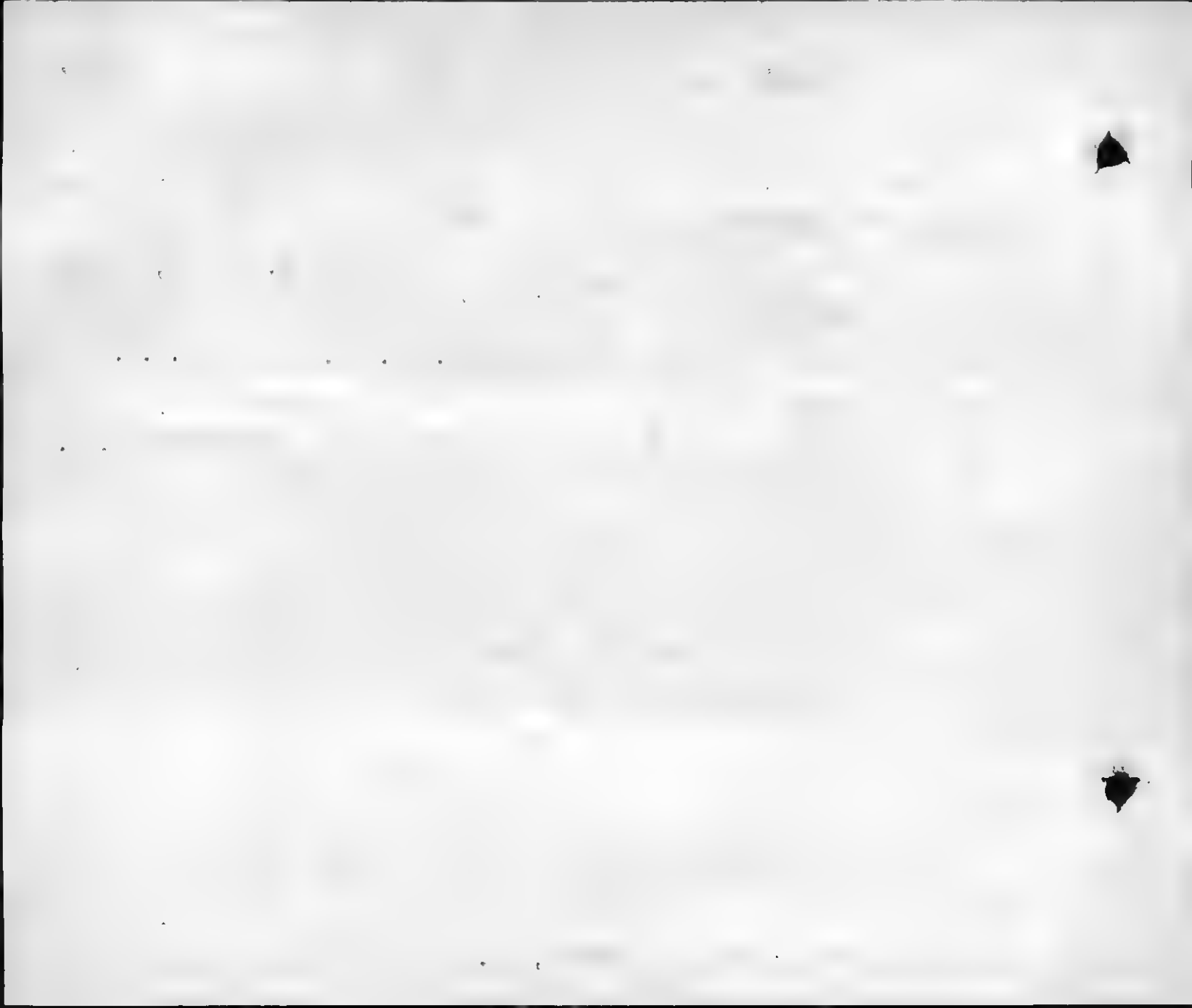
CERTIFICATE OF DEATH

02443

Item 23d, Film G307 2/1/62 iwk

02431

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN IL 2 1/2	
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BIG POOL	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GATEWAY CONVELESANT HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS RURAL	
3. NAME OF DECEASED (Type or print) RACHAEL MARY MASON		4. DATE OF DEATH FEB. 4, 1962		5. SEX FEMALE	
6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/17/1878	
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 4 Days 17		11. BIRTHPLACE (County & State, or foreign country) WASH. CO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES CHANEY		14. MOTHER'S MAIDEN NAME CEILIE BOWMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) NONE		16. SOCIAL SECURITY NO. NONE		17. INFORMANT CLARENCE MASON PECKTONVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Diabetes Mellitus DUE TO cause last (c) Arterial Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 5 yrs. 10 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, or item 18.)		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 11, 1962 to Feb 4, 1962 that (I) (we) last saw the deceased alive on Feb 3, 1962 and that death occurred at 8:30 A.M. from the causes and on the date stated above.		22a. SIGNATURE David R. Brewer		22b. DATE SIGNED 2/5/62	
22c. PHYSICIAN'S NAME (Type) David R. Brewer		22d. ADDRESS Clear Spring Md.		22e. REC'D BY REGISTRAR FEB 8 '62	
22f. REGISTRAR'S SIGNATURE William S. Kline		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/6/62	
23c. NAME OF CEMETERY OR CREMATORY PARKHEAD CEMETERY		23d. LOCATION (City, town or county) (State) Washington County, Md.		23e. ADDRESS CLEAR SPRING, MD.	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02444

02432

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN TB 8 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1301 Marshall St		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland f. COUNTY Washington g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown h. STREET ADDRESS 1301 Marshall St	
3. NAME OF DECEASED (Type or print) HARVEY LEWIS MAUGANS 4. DATE OF DEATH Feb 7 19 62		i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH June 14 1904 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR, Months Days Hours Min. IF UNDER 2- HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant 10b. KIND OF BUSINESS OR INDUSTRY Self Employed York York Co Pa. 12. CITIZEN OF WHAT COUNTRY? USA	
11. FATHER'S NAME Harvey L. Maugans Sr. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		14. MOTHER'S MAIDEN NAME Florence Slick 16. SOCIAL SECURITY NO 220-18-0304 17. INFORMANT Mrs N. Irene Maugans	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) Hagerstown Md.	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at A.M. , from the causes and on the date stated above.		22a. SIGNATURE 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 22e. MED. DIRECTOR <input type="checkbox"/> 22f. STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/10/62 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City, town or county) Hagerstown Wash Co Md.		24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md. 25a. REC'D BY REGISTRAR DATE FEB 13 '62 25b. REGISTRAR'S SIGNATURE W. H. S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, & 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02445

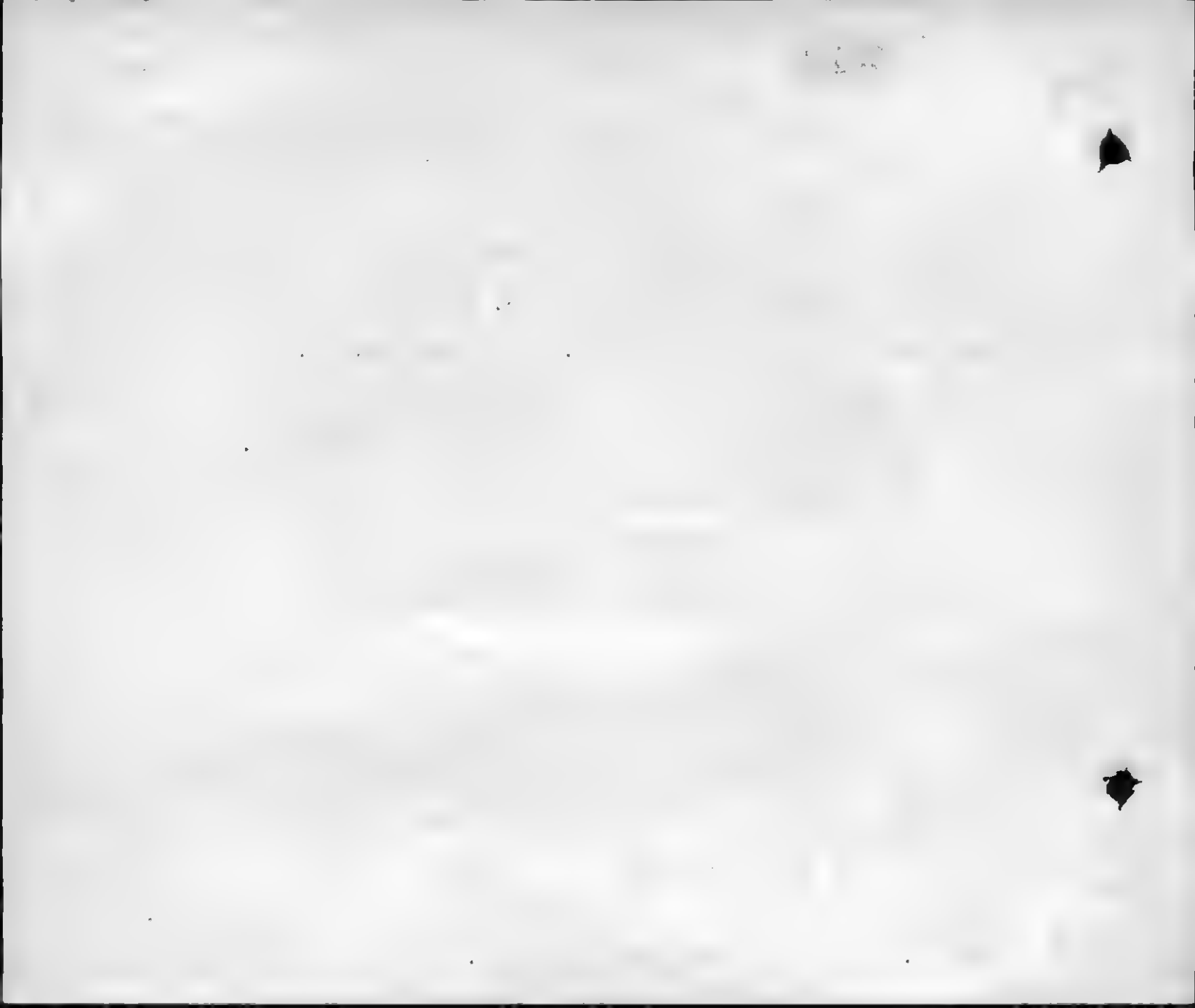
CERTIFICATE OF DEATH

02433

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 724 Medway Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barry Edward Miller		4. DATE OF DEATH February 10 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1875
9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hauling	
11. BIRTHPLACE (County & State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alex Miller		14. MOTHER'S MAIDEN NAME Ann Proctor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Leon Hoover Norfolk, Va.	
17. INFORMANT Leon Hoover Norfolk, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Nephrosclerosis DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
INTERVAL BETWEEN ONSET AND DEATH 7 1/2 Indefinite			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 1962 Hour a.m. 11 p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/16/62 to 2/10/62 , that (I) (we) last saw the deceased alive on 2/10/62 and that death occurred at 9:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Campbell M.D.			
22b. DATE SIGNED 2/10/62			
22c. PHYSICIAN'S NAME (Type) Robert W. Campbell			
22d. ADDRESS 1454 Washington St Hagerstown, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial			
23b. DATE THEREOF 2-13-62			
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			
23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son ADDRESS Hagerstown, Md.			
25a. REC'D BY REGISTRAR Feb 15 '62			
25b. REGISTRAR'S SIGNATURE C. S. Evans			

VR A15 (4)
15M 9/60

Parker



4. 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02431											
1. PLACE OF DEATH a. COUNTY WASHINGTON				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND				b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 2 HOURS				c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 941 PRESTON ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RICHARD ARTHUR MOTZ JR.				4. DATE OF DEATH FEBRUARY 18 1962				5. SEX MALE			
6. COLOR OR RACE WHITE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>				8. DATE OF BIRTH MAY 23 1944			
9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) Months Days Hours Min. 17 yrs.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) HAGERSTOWN MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME RICHARD ARTHUR MOTZ SR.			
14. MOTHER'S MAIDEN NAME JANE E HARMS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT RICHARD A MOTZ SR. HAGERSTOWN MARYLAND				Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gas. car Skull fracture & Brain Stem injury and Intracranial Hemorrhage											
DUE TO (b) Internal Jugular Vein											
DUE TO (c) Internal Jugular Vein											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Internal Jugular Vein											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Collision with train while driving auto							
20c. TIME OF INJURY Month, Day, Year 2-17-62				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Northtown Rd Hagerstown Wash MD			
20f. (City or town) Hagerstown				20g. (County) Washington				20h. (State) MD			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE E.W. DITTO JR.				M.D. E.W. DITTO JR.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E.W. DITTO JR.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 2/19/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2-20-62				22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY			
22d. LOCATION (City, town, or country) HAGERSTOWN MARYLAND				22e. ADDRESS 213 W WASHINGTON ST.				22f. LOCATION (City, town, or country) HAGERSTOWN MD.			
23. FUNERAL DIRECTOR SUTER-ROUZER FUNERAL HOME				24a. REC'D BY REGISTRAR FEB 26 '62				24b. REGISTRAR'S SIGNATURE Charles S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02447
CERTIFICATE OF DEATH
02135

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b. <u>1 1/2 Hr</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 4</u> d. STREET ADDRESS <u>Cearfoss</u>	
3. NAME OF DECEASED (Type or print) <u>EDITH MERLE MYERS</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>March</u> Day <u>31</u> Year <u>1897</u>	
9. AGE (In years, if UNDER 1 YEAR, if UNDER 24 HRS, last birthday) <u>64</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. FATHER'S NAME <u>John Daniel Shank</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Perrott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMATION a. PRESTON E. MYERS HAGERSTOWN MD R # 4 b. MARYLAND c. INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> d. <u>7 yrs</u>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arterio Sclerotic Heart Disease</u> DUE TO (b) <u>Dilated</u> DUE TO (c) <u>Thrombosis</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>	
21. 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		22. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
23. 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>11</u> p.m. <u>17</u>		24. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		26. 20f. (City or town) <u>Hagerstown</u> (County) <u>Washington</u> (State) <u>MD</u>	
27. I certify that (I) (this hospital) attended the deceased from <u>1-17-62</u> to <u>2-17-62</u> , that (I) (we) last saw the deceased alive on <u>2-17-62</u> , and that death occurred <u>11 PM</u> , from the causes and on the date stated above.		28. 21. SIGNATURE <u>A. K. Coffman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE <u>2/17/62</u>	
29. 22c. PHYSICIAN'S NAME (Type) <u>Dr. F. W. D. T. O. P.</u>		30. 22d. ADDRESS <u>Hagerstown Md</u>	
31. 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		32. 23b. DATE THEREOF <u>2/20/62</u>	
33. 23c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>		34. 23d. LOCATION (City, town or county) <u>Broadfording</u> (State) <u>Washington Co Md.</u>	
35. 24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>		36. 25a. REC'D BY REGISTRAR <u>FEB 21 '62</u> DATE <u>FEB 21 '62</u>	
37. 25b. REGISTRAR'S SIGNATURE <u>Wm. L. Thomas</u>		38. 26. REGISTRAR'S SIGNATURE <u>Wm. L. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02448

02436

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN

40 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington County Hospital

3. NAME OF DECEASED
(Type or print)

Isaiah

Franklin

Myers

5. SEX

Male

White

6. COLOR OR RACE

WIDOWED

DIVORCED

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

Mar. 4, 1913

9. AGE (In years last birthday)

48 yrs.

10. F UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Driver

Oil Co.

Near Hagerstown, Md.

13. FATHER'S NAME

Isaiah Myers

14. MOTHER'S MAIDEN NAME

Anne Hastings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

212-14-7126

17. INFORMANT

Mrs. Arlene L. Myers Hagerstown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

*Congestive failure & cardiac hypertrophy
intermediate Heart Disease (?)*

INTERVAL BETWEEN ONSET AND DEATH

1 day

no

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 19....., to 2/4/62....., 19....., that (I) (we) last saw the deceased alive on 2/4/62....., and that death occurred at 6:00 M, from the causes and on the date stated above.

22a. SIGNATURE

Howard N. Weeks

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS ☐

22b. DATE SIGNED

2/5/62

22c. PHYSICIAN'S NAME (Type)

Howard N. Weeks

22d. ADDRESS

136 N. Potomac St. Hag. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

2-8-62

23c. NAME OF CEMETERY OR CREMATORY

Cedar Lawn Mem. Gardens

23d. LOCATION (City, town or county)

Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE

Scott F. Minnich & Son Hagerstown, Md.

25a. REC'D BY REGISTRAR

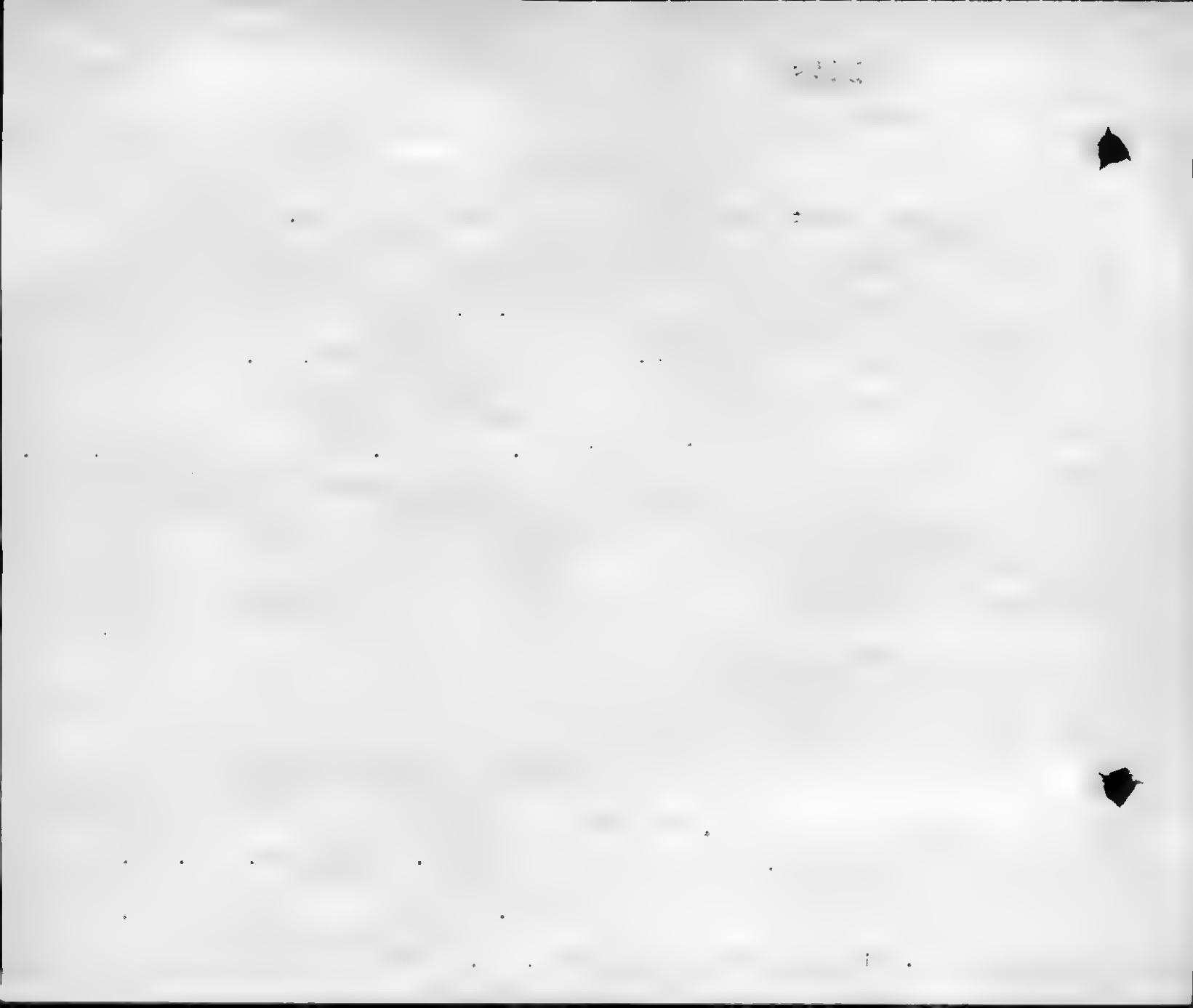
DATE FEB 8 '62

25b. REGISTRAR'S SIGNATURE

Wm. L. Thomas

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VR A15 (4)
15M 9/60



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MARYLAND STATE DEPARTMENT OF HEALTH

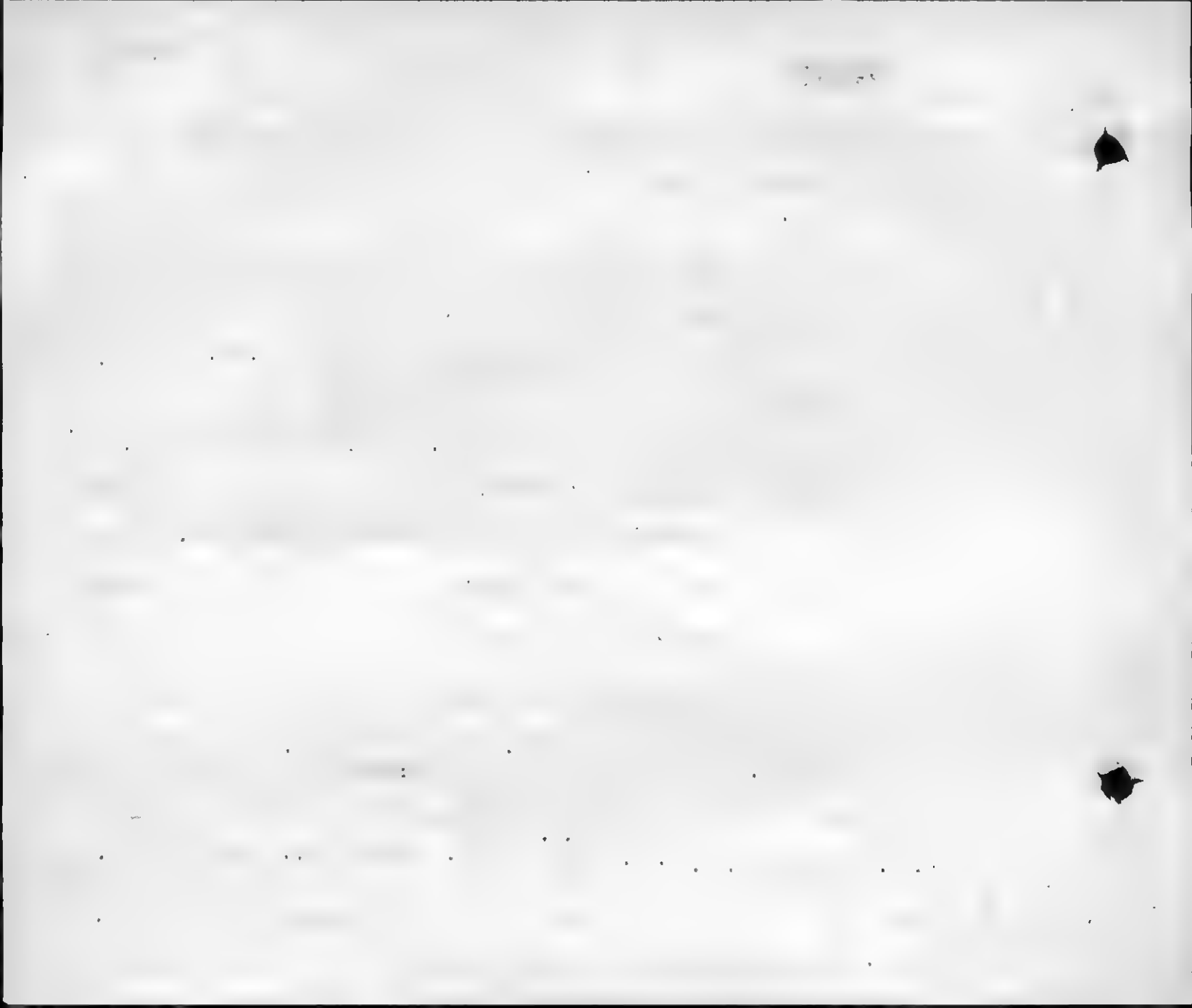
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02449

02437

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>3 wks.</u>		d. STREET ADDRESS <u>405 Edgewood Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CATHERINE MARY NINER</u>		4. DATE OF DEATH February 28 1962	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>		8. DATE OF BIRTH <u>June 10, 1899</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Midland, Allegany Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Morris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-2695</u>	
17. INFORMANT <u>Herbert E. Niner, 405 Edgewood Dr.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>Hypertensive arteriosclerotic cardiovascular dis.</u> DUE TO (c) <u>Congestive heart failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Congestive heart failure</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 28</u> , 19 <u>62</u> , to <u>Feb. 28</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Feb. 28</u> , 19 <u>62</u> , and that death occurred at <u>5:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. C. Stauffer, M.D.</u>		22b. DATE SIGNED <u>3-1-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. C. Stauffer, M.D. / W. N. Fender</u>		22d. ADDRESS <u>145 S. Prospect St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/3/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Maryland</u>		25a. REC'D BY REGISTRAR <u>5 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>L. K. K...</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02450 CERTIFICATE OF DEATH 02138

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport		c. LENGTH OF STAY IN 1b 57 yrs.	
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport Md. RFD #1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Williamsport Md. RFD #1		d. STREET ADDRESS Williamsport Md. RFD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Belle Palmer		4. DATE OF DEATH Feb. 7 1962		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25 1877	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 10 Days 12		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTH-PLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lottie Haugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frances Miller Williamsport Md RFD #1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse carcinomatosis 1-1-62 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Large Bowel Carcinoma DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) None		INTERVAL BETWEEN ONSET AND DEATH 1 mo		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-23-61, to 2-7-62 that (I) (we) last saw the deceased alive on 1-18-62 and that death occurred at 3:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE M.E. Byrkit		22b. DATE SIGNED 2-8-62		22c. PHYSICIAN'S NAME (Type) M.E. Byrkit Williamsport Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 10-62		23c. NAME OF CEMETERY OR CREMATORY Giverview Cemetery	
23d. LOCATION (City, town or county) (State) Williamsport Md.		24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Wolf Williamsport Md		25a. REC'D BY REGISTRAR DATE FEB 9 '62	
25b. REGISTRAR'S SIGNATURE C. H. H. H.		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02451

CERTIFICATE OF DEATH

02439

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SMITHSBURG</u> c. LENGTH OF STAY IN b. <u>2 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HAGERSTOWN MD R.I.</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional on. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL NEAR SMITHSBURG</u> d. STREET ADDRESS <u>SMITHSBURG MD R.I.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAUDE A. PALMIER</u>		4. DATE OF DEATH <u>FEBRUARY 12, 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 24, 1886</u>
9. AGE (In years (if under 1 year last birthday) Months Days Hours M n.) <u>75 yrs. 3 18</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BOONSBURG WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES A. GABE</u>		14. MOTHER'S MAIDEN NAME <u>LUCINDA DANNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-09-8313</u>	
17. INFORMANT <u>HARRY S. PALMIER</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 221X DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>1-8</u> , 19 <u>56</u> to <u>2-12</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>6-12</u> , 19 <u>62</u> , and that death occurred at <u>6:57 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles F. Hess</u> M.D.		22b. DATE SIGNED <u>2-13-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>		22d. ADDRESS <u>Smithsburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 15, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Bad</u>		25a. REC'D BY REGISTRAR <u>DATE 16 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Boonsboro MD</u>		25c. REGISTRAR'S SIGNATURE <u>Charles S. Knaus</u>	

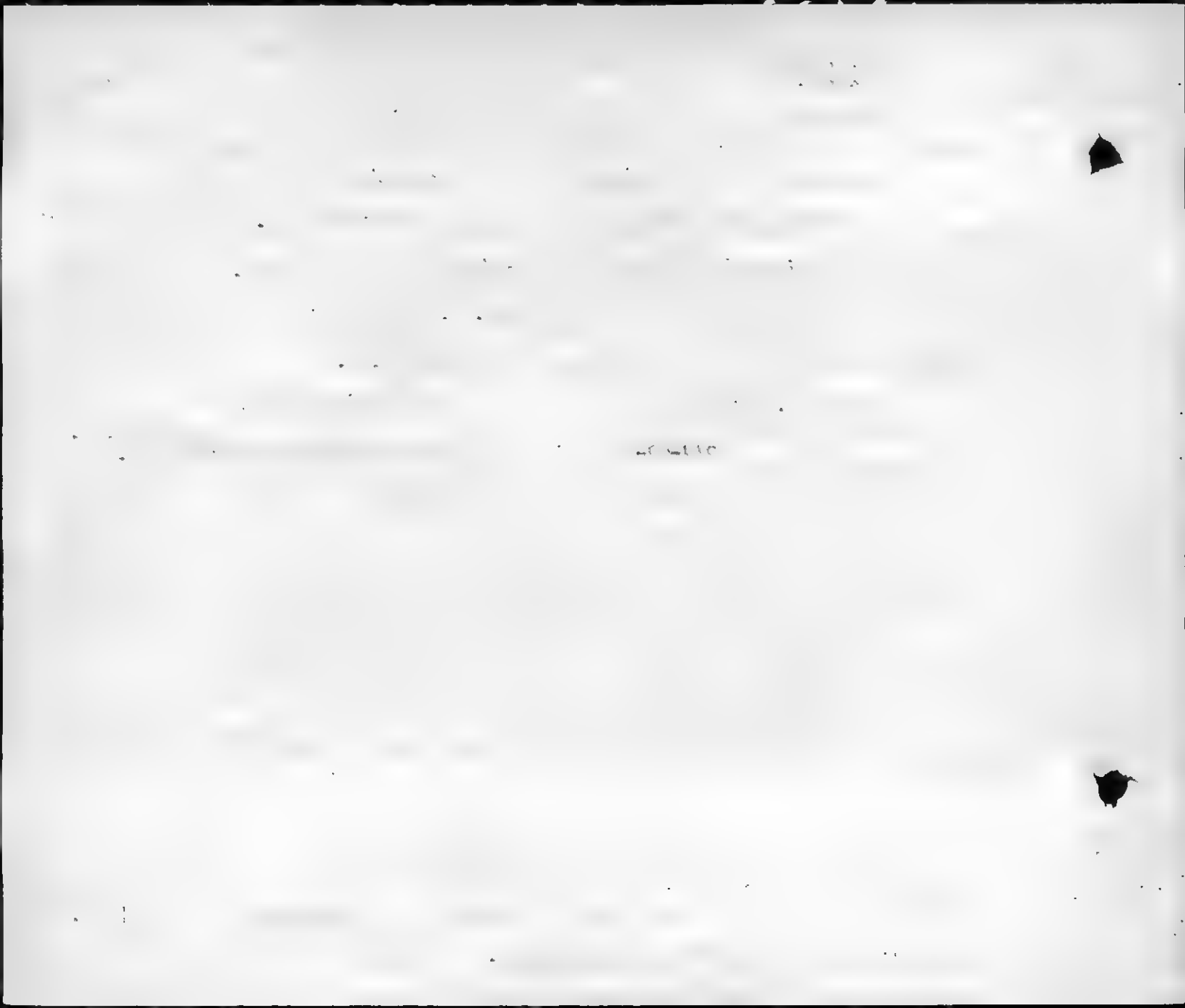


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02452					02140									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)									
a. COUNTY		Washington			a. STATE		Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown			b. COUNTY		Washington							
c. LENGTH OF STAY IN 1b		Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Washington County Hospital			d. STREET ADDRESS		229 Alexander St.							
e. IS RESIDENCE ON A FARM?							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last					Month Day Year									
Richard Henry Randall					Feb. 8 1962									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Male		White				Sept. 30, 1907		54 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?								
Carpenter		Construction		Hagerstown, Md.		USA								
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Harry C. Randall					Ocia Deville Baker									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
No					214-09-9793					Miss Catherine Randall 229 Alexander St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										6 mos.				
DUE TO										1 week				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										5 yrs				
DUE TO														
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?				
none										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED				
Hour a.m. p.m.										While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Sept. 30, 1907 to Feb. 8, 1962; that (I) (we) last saw the deceased alive on Feb. 8, 1962; and that death occurred on Feb. 8, 1962, from the causes and on the date stated above.														
22a. SIGNATURE										22b. DATE SIGNED				
Joseph G. Crisp M.D.										2-11-62				
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS				
JOS C. CRISP										115 King St. Hagerstown				
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF				
Burial										2/11/62				
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)				
Rest Haven Cemetery										Hagerstown Md.				
24. FUNERAL DIRECTOR'S SIGNATURE										25a. REC'D BY REGISTRAR				
Rest Haven Funeral Chapel										DATE FEB 13 '62				
Wm. G. Horst										25b. REGISTRAR'S SIGNATURE				
										C. W. S. Thomas				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

<div> <div>1</div> <div>02453</div> <div>02141</div> </div> <div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div> <div>1</div> <div>02453</div> <div>02141</div> </div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>52 Fairgreen Circle</u>					
3. NAME OF DECEASED (Type or print) <u>Mary Sloan Reisner</u>						4. DATE OF DEATH <u>February 27 1962</u>					
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 16, 1877</u> 9. AGE (in years) (IF UNDER 1 YEAR IF UNDER 24 HRS by birthday) <u>84</u> yrs. Months Days Hours Min						10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (State or foreign country) <u>McConnellsburg, Pa.</u> 12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Thomas F. Sloan</u> 14. MOTHER'S MAIDEN NAME <u>Josephine Alexander</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> 16. SOCIAL SECURITY NO. <u>---</u> 17. INFORMANT <u>W. H. Reisner Jr.</u> Address <u>Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>Fracture Of Femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Became dizzy while walking fell fracturing her hip.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>10 2-26 19 62</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Hagerstown, Washington, Md.</u> (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>W. H. Reisner Jr.</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2-28-62</u> EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>March 1, 1962</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u> 22d. LOCATION (City, town, or country) <u>McConnellsburg, Pa.</u> (State)											
23. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u> ADDRESS <u>Hagerstown, Md.</u> 24a. REC'D BY REGISTRAR <u>2-28-62</u> 24b. REGISTRAR'S SIGNATURE											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02454

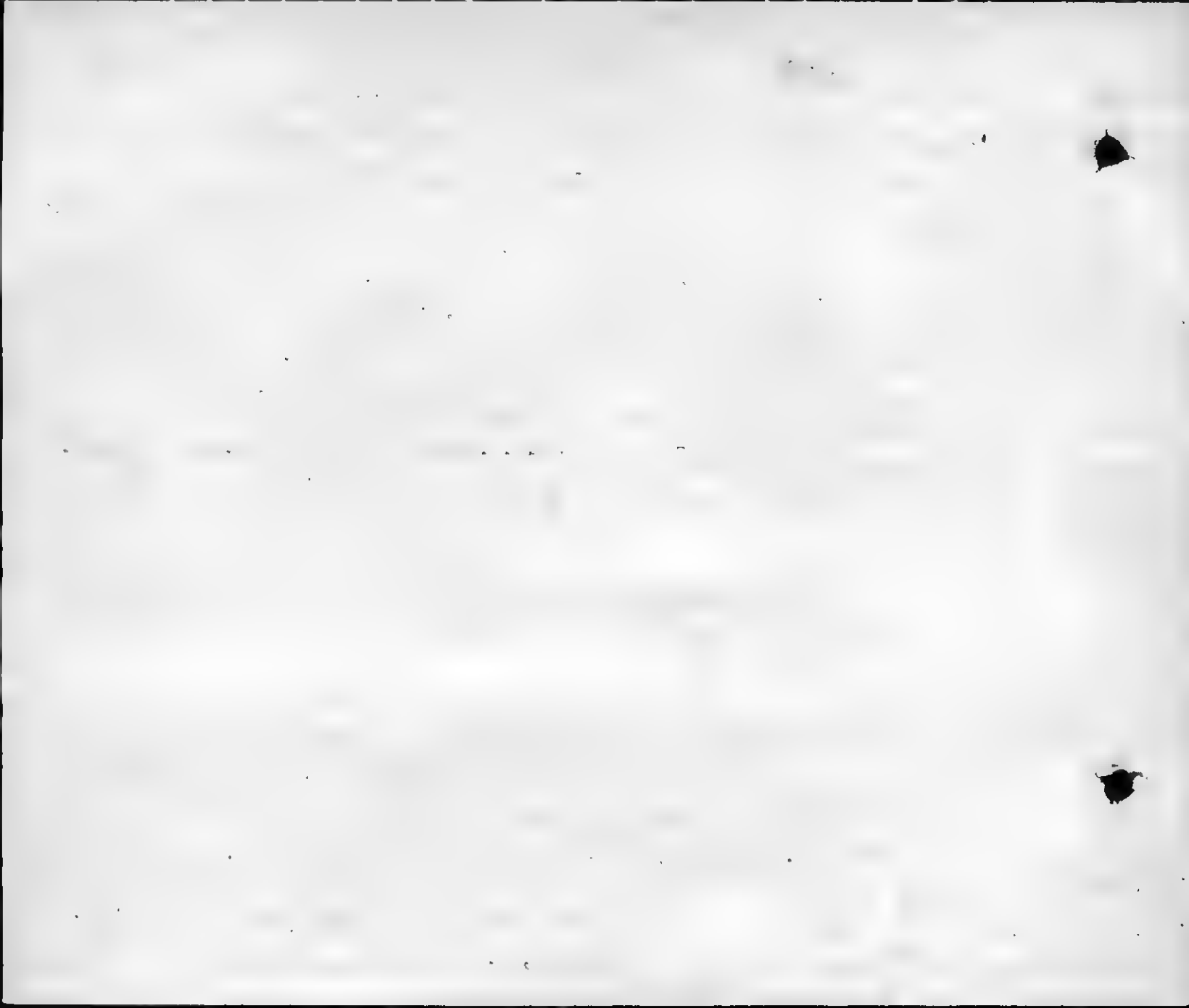
CERTIFICATE OF DEATH

02442

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN it <u>31 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>950 Kenwood Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Davidson</u> Last <u>Riley</u>		4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1962</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 7, 1907</u>		9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Shippensburg, Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>George Howard Riley</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Rosanne Davidson</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>705-10-4941</u>				17. INFORMANT <u>Mrs. H.D. Riley</u> Address <u>950 Kenwood Dr. Hagerstown, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Chronic reticulosis due to old histoplasmosis</u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21 I certify that (I) (this hospital) attended the deceased from <u>July 18, 1961</u> to <u>Feb. 1, 1962</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Feb. 1, 1962</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Edward W. Ditto III, M.D.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>217 West Washington St.</u>				22b. DATE SIGNED <u>2/3/62</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/4/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				23d. LOCATION (City, town or county) <u>Hagerstown</u> (State) <u>Md.</u>					
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Hawk</u>						25a. REC'D BY REGISTRAR <u>Feb 5 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

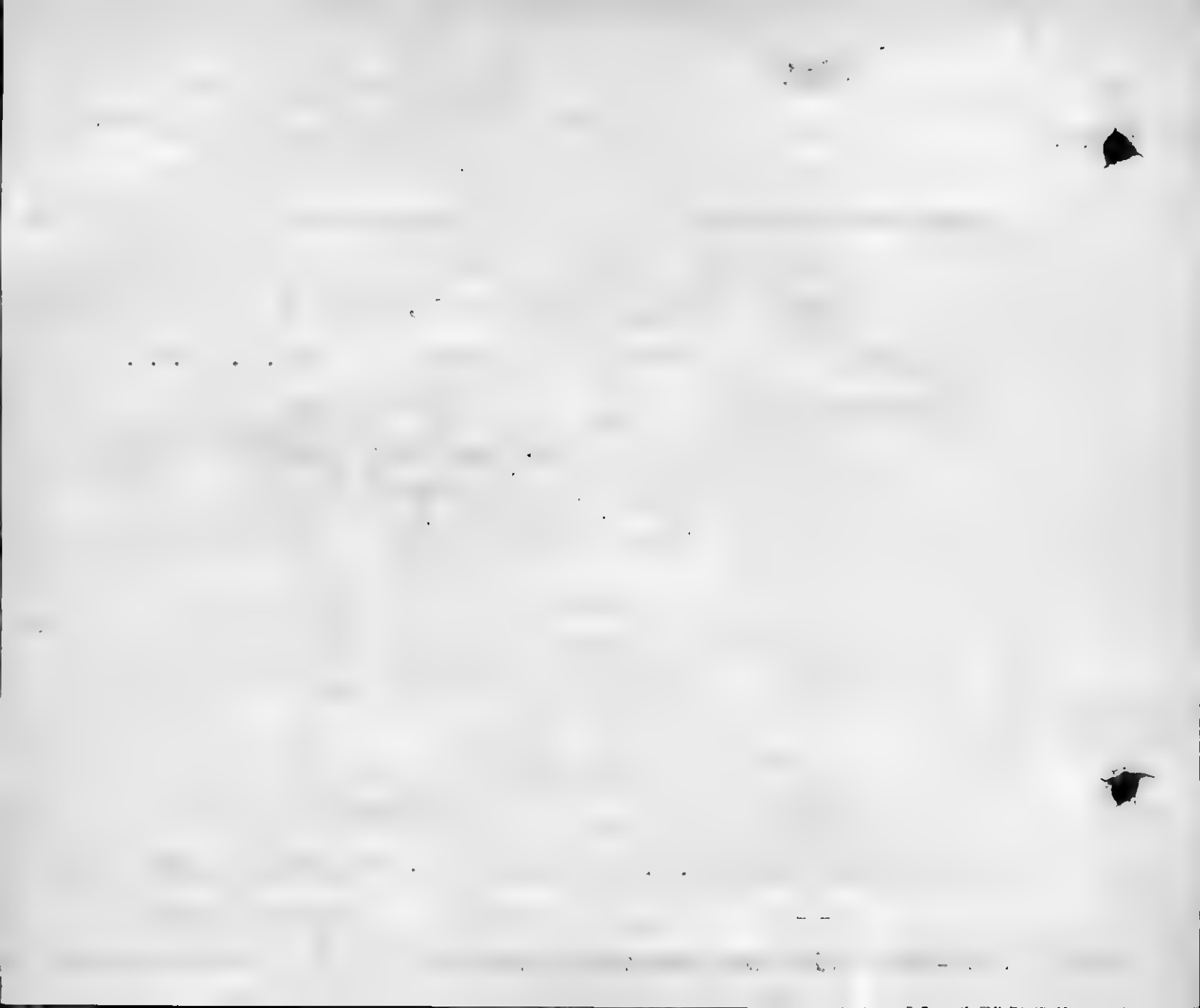
02455

02443

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>RURAL WILSONS DISTRICT</u>				c. LENGTH OF STAY IN IN <u>16 MONTHS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GATEWAY CONVALESCENT HOME</u>				e. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>132 McCOMAS STREET</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WILLIAM</u> Last <u>SAGER</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>1</u> Year <u>19 62</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 11, 1889</u>	
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTERING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SHENANDOAH JUNCTION W.VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JAMES SOLOMON SAGER</u>			
14. MOTHER'S MAIDEN NAME <u>FRANCES FLOOK</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>MRS. GEORGE MEYER HAGERSTOWN MARYLAND</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Hepatitis</u> <u>SOX</u> DUE TO (b) <u>Arterio Sclerotic Cardiac Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>2 yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1962</u> to <u>Feb 1, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb 1, 1962</u> and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>David R. Brewer</u>				22b. DATE SIGNED <u>Feb 1, 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>DAVID R. BREWER M. D.</u>	
22d. ADDRESS <u>MAIN ST. CLEAR SPRING MARYLAND</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-3-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MARYLAND</u>	
24. UNUSUAL DIRECTOR'S SIGNATURE <u>Charles M. Rieger</u>				25a. REC'D BY REGISTRAR <u>Feb 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>	
26. SUTHER-ROUZER FEDERAL HOME HAGERSTOWN MARYLAND							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

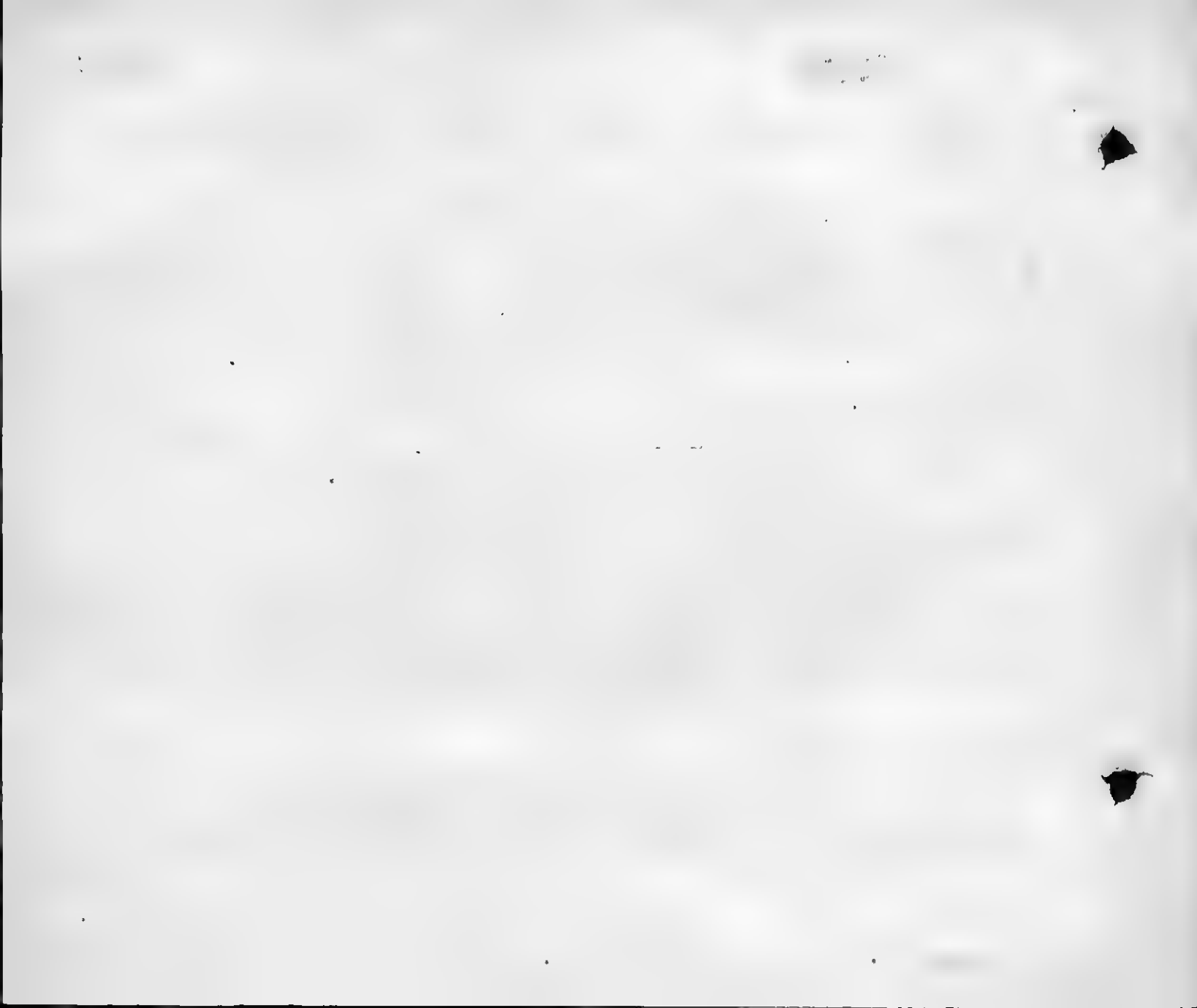
CERTIFICATE OF DEATH

02456

02444

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boonsboro		c. LENGTH OF STAY IN b 8 Mos		2. USUAL RESIDENCE (Where deceased lived, if instit on: Residence before adm ssion) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 47 Delwood Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARENCE NEWTON SAUM		4. DATE OF DEATH Feb 9 1962		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7 1886		9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months 2 Days 19 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motel Operator		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTH PLACE (County & State, or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George C. Saum		14. MOTHER'S MAIDEN NAME Sina Worden		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 314-09-7608		17. INFORMANT Mrs Vera C. Saum 47 Delwood Ave Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis with senility DUE TO (b) Senility DUE TO (c) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 10 1962 to Feb 9 1962 , that (I) (we) last saw the deceased alive on Feb 8 1962 , and that death occurred at 5 P.M. from the causes and on the date stated above.		22a. SIGNATURE G. W. Llan		22b. DATE SIGNED 2/10/62		22c. PHYSICIAN'S NAME (Type) G. W. Llan		22d. ADDRESS Boonsboro		22e. STATE Md		22f. CITY OR TOWN Boonsboro		22g. COUNTY Washington		22h. STATE Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/62		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.		25a. REC'D BY REGISTRAR FEB 13 '62		25b. REGISTRAR'S SIGNATURE William S. Thomas		25c. DATE FEB 13 '62		25d. REGISTRAR'S SIGNATURE William S. Thomas		25e. DATE FEB 13 '62	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24b. ADDRESS Hagerstown Md.		24c. CITY OR TOWN Hagerstown		24d. COUNTY Washington		24e. STATE Md		24f. CITY OR TOWN Hagerstown		24g. COUNTY Washington		24h. STATE Md		24i. DATE FEB 13 '62	

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15M 9/60



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. M I

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

02457

02445

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Hagerstown
c. LENGTH OF STAY IN 1b 9 Months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Gate Way Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hancock Maryland
d. STREET ADDRESS Hancock Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Charles Mathias Sensel
First Middle Last
4. DATE OF DEATH 2 6 19 62
Month Day Year

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Jan. 27, 1880
WIDOWED ☐ DIVORCED ☐ 9. AGE (in years last birthday) 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY Carpenter 11. BIRTHPLACE (County & State, or foreign country) Hancock Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Sensel 14. MOTHER'S MAIDEN NAME Rebecca L. Weaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No 16. SOCIAL SECURITY NO. 211.16.4124A 17. INFORMANT Miss Mary Sensel Address 18 W. High St. Hancock Md.

18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia
467.0 E.J.L. TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Hypotensive Sclerosis
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

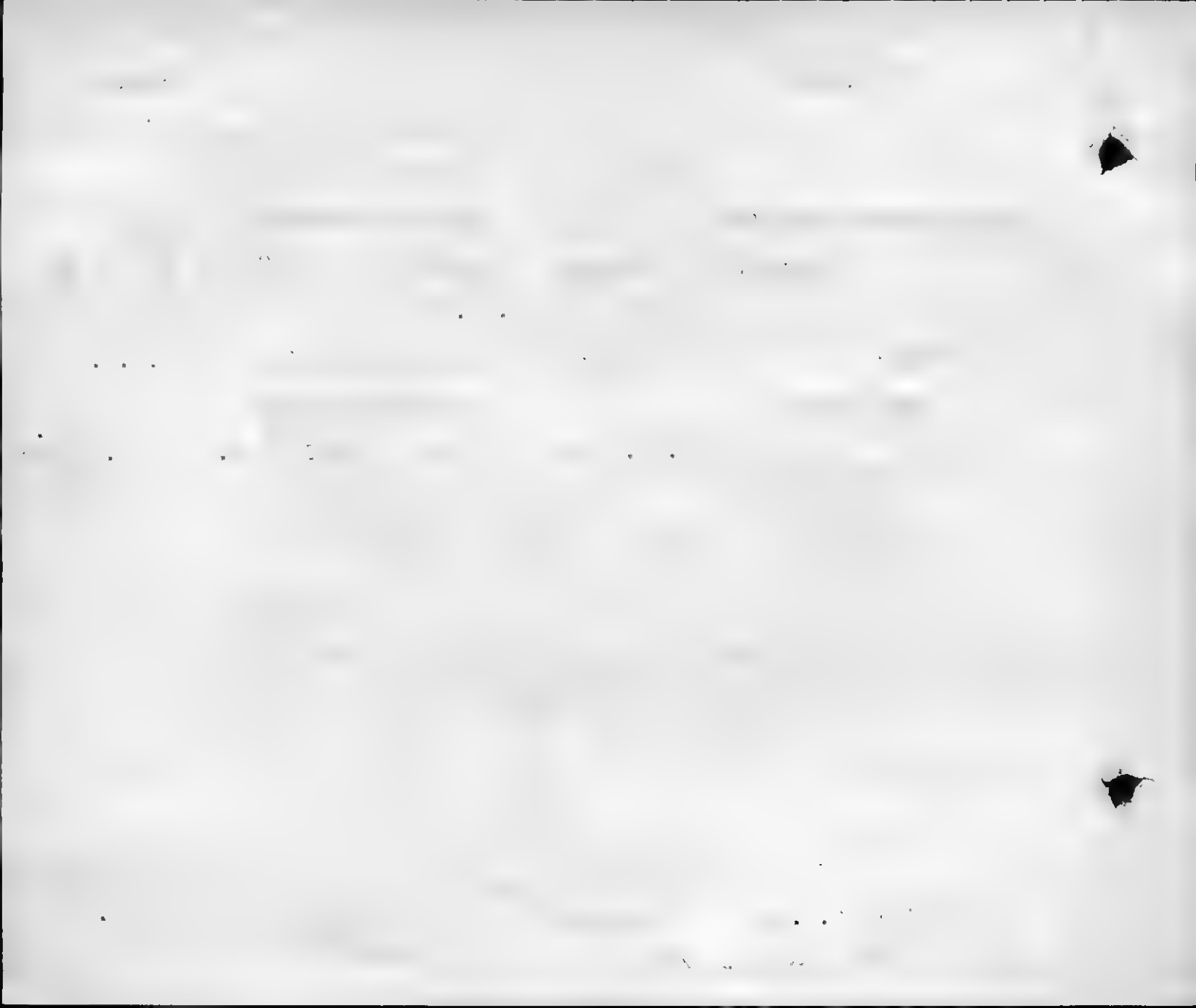
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 22, 1962 to Feb 6, 1962, that (I) (we) last saw the deceased alive on Feb 2, 1962 and that death occurred at 12 P.M. from the causes and on the date stated above.

22a. SIGNATURE David R. Brewer M.D. 22b. DATE SIGNED 2/8/62
22c. PHYSICIAN'S NAME (Type) David R. Brewer 22d. ADDRESS Clear Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2.9.62 23c. NAME OF CEMETERY OR Tonoloway Baptist 23d. LOCATION (City, town or county) (State) Fulton County Penna.

24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Brown, Hancock, Md. 25a. REC'D BY REGISTRAR DATE FEB 13 '62 25b. REGISTRAR'S SIGNATURE J. S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02458					02446				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>WASHINGTON</u>					a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FUNKSTOWN</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FUNKSTOWN</u>				
c. LENGTH OF STAY IN 1b <u>34 YEARS</u>					d. STREET ADDRESS <u>101 EAST MAPLE STREET</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>101 EAST MAPLE STREET</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>WILBUR WELLINGTON SHEPLEY</u>					4. DATE OF DEATH <u>FEBRUARY 14 19 62</u>				
5. SEX <u>MALE</u>					6. COLOR OR RACE <u>WHITE</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>NOV 12 1894</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARMAN</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>MYERSVILLE MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>JOHN CLAYTON SHEPLEY</u>					14. MOTHER'S MAIDEN NAME <u>SUSAN GROSSNICKLE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>705-10-8646</u>				
17. INFORMANT <u>MRS. WILBUR W SHEPLEY FUNKSTOWN MARYLAND</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u>									
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic coronary artery disease</u>									
(c) <u>Generalized arteriosclerosis</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASTHMA</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>none 19</u>									
20d. INJURY OCCURRED While at work Not While at work <input type="checkbox"/> <u>none</u>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>July 26, 1961</u> to <u>Feb. 14, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 13, 1962</u> , and that death occurred at <u>1:30 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Harold R. Titch Jr</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2-15-62</u>									
22c. PHYSICIAN'S NAME (Type) <u>H R TRITCH JR M. D.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>									
23b. DATE THEREOF <u>2-16-62</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>									
23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MARYLAND</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Rouzer</u> ADDRESS <u>SUTHER ROUZER FUNERAL HOME HAGERSTOWN MARYLAND</u>									
25a. REC'D BY REGISTRAR <u>Charles S. Kincaid</u>									
25b. REGISTRAR'S SIGNATURE <u>Charles S. Kincaid</u>									
DATE <u>FEB 19 '62</u>									



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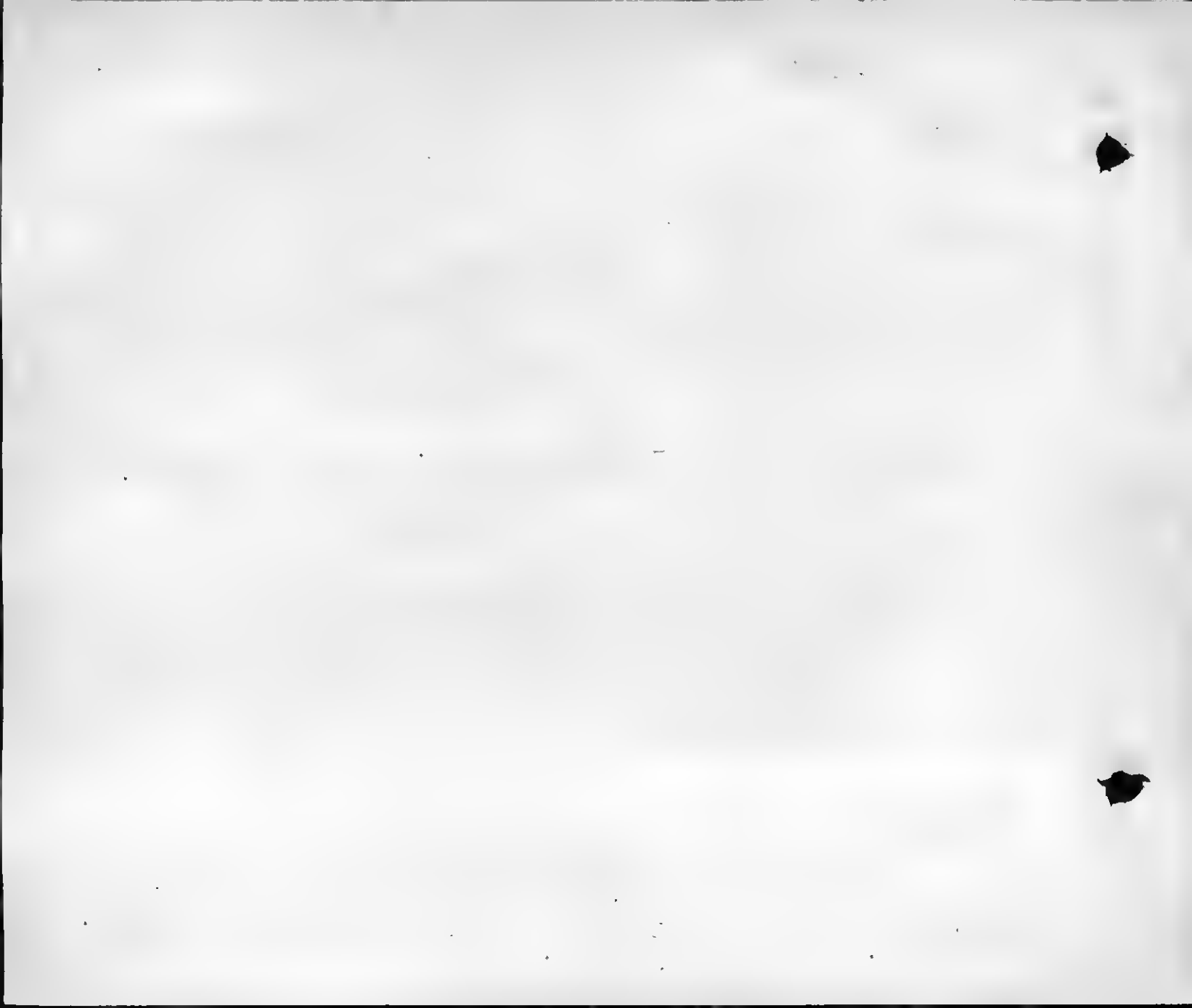
M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02459 CERTIFICATE OF DEATH 02417

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 Mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>931 Salem Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN RAYMOND SHETRON</u>		4. DATE OF DEATH <u>FEB. 12 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upper Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hag Shoe Co</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Pa</u>
13. FATHER'S NAME <u>Jacob Shetron</u>		14. MOTHER'S MAIDEN NAME <u>Ella Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-9238</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY CONGESTION</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL THROMBOSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>HYPERTENSIVE HEART DISEASE - PULMONARY EMPHYSEMA</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>3 MONTHS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>1-16-</u> , 19 <u>62</u> , to <u>2-12-</u> , 19 <u>62</u> , that (I) (was) last saw the deceased alive on <u>2-12-</u> , 19 <u>62</u> , and that death occurred at <u>2:35</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Antonio U. Pallagrosi</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGROSI</u>		22d. ADDRESS <u>1500 Pa Ave Hagerstown Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/15/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>FEB 15 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>John L. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

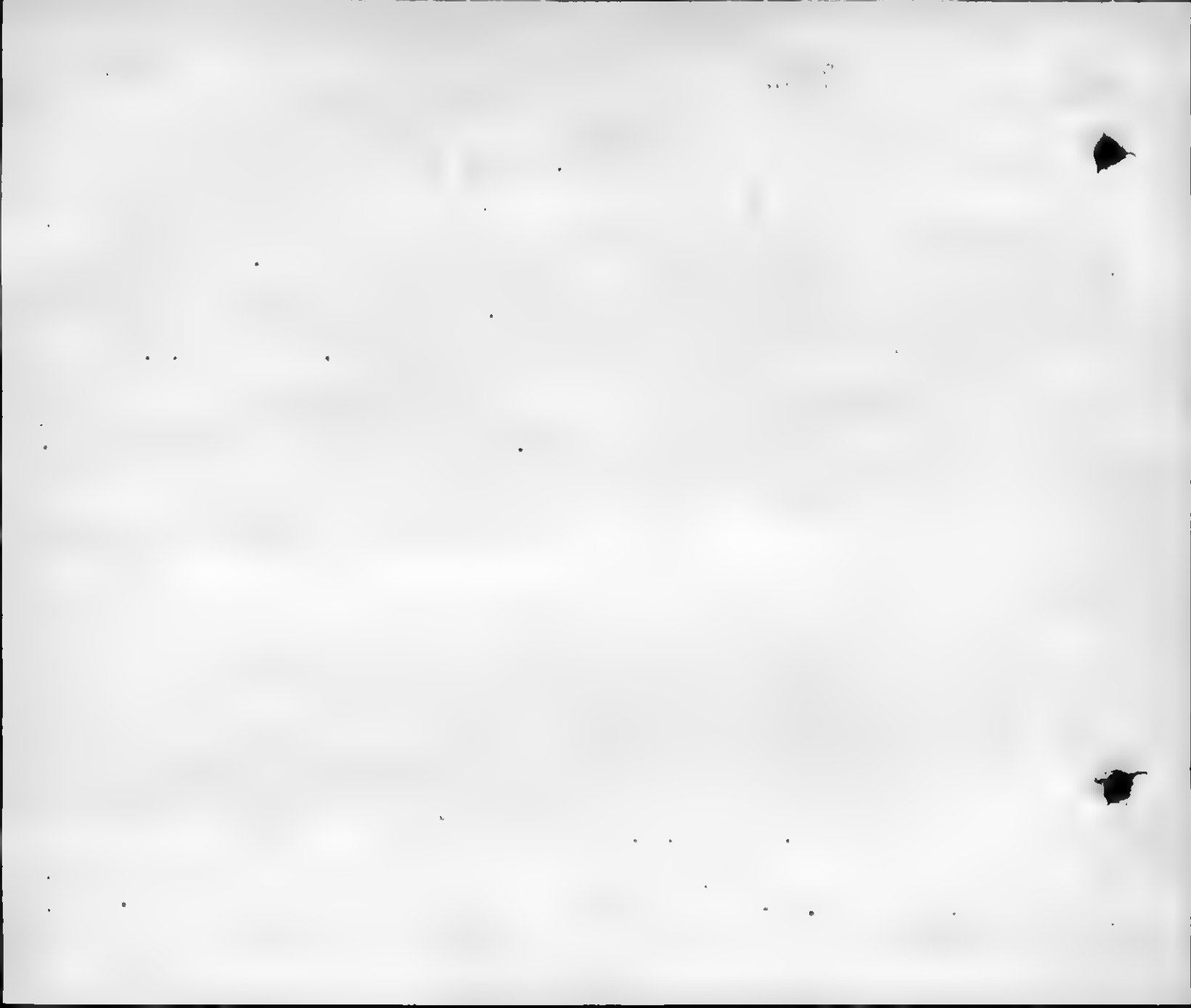
VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02460

02148

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport</u> c. LENGTH OF STAY IN b. <u>25 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport RFD #1</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport</u> d. STREET ADDRESS <u>Williamsport RFD #1</u>	
3. NAME OF DECEASED (Type or print) <u>John Wesley Shipley</u>		4. DATE OF DEATH <u>Feb. 1 19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Downsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Urilla Hammond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 14 6690</u>	
17. INFORMANT <u>Mrs. Edna Mae Shipley Williamsport Md.</u>		Address <u>RFD 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerotic Heart Disease</u> (c) <u>6 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>July 19 61</u> to <u>February 19 62</u> , that (I) (we) last saw the deceased alive on <u>Jan 21 1962</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edson B. Moody</u> Edson B. Moody, M. D. 145 South Prespect Street		22b. DATE SIGNED <u>2/2/62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 4-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Williamsport Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 6 1962</u>	
25b. REGISTRAR'S SIGNATURE <u>C. L. L. L.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. DITTO

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MEDICAL CERTIFICATION

M											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02461											
02449											
1. PLACE OF DEATH a. COUNTY WASHINGTON				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				b. COUNTY WASHINGTON							
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. CO. HOSPITAL				d. STREET ADDRESS 31 West Franklin St.							
3. NAME OF DECEASED (Type or print) VERNON H. SHOWE				4. DATE OF DEATH FEBRUARY 10 1962				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 30 1899		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EMPLOYEE FAIRCHILD AIRCRAFT				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) TILGHMANTON WASH. CO. MD U.S.A.		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME ISIAH SHOWE				14. MOTHER'S MAIDEN NAME ESTA HAYS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO			
16. SOCIAL SECURITY NO. 220-10-3705				17. INFORMANT MRS MARY SHOWE				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic duodenal ulcer with perforation 4 days 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) and peritonitis - DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Bicuspid aortic valve, Nodular hyperplasia prostate, Coronary sclerosis, Cachexia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Feb 4, 1962, to Feb 10, 1962, that (I) (not) last saw the deceased alive on Feb 10, 1962, and that death occurred at 12:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Edward W. Ditto III, M.D.				22b. DATE SIGNED 2/11/62				22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF FEB 12 1962				23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW CEMETERY SHARPSBURG WASH. CO. MD			
24. FUNERAL DIRECTOR'S SIGNATURE John H. East				24b. ADDRESS BOONSBORO MD				25a. REC'D BY REGISTRAR DATE FEB 16 '62			
25b. REGISTRAR'S SIGNATURE Charles E. Kline											



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

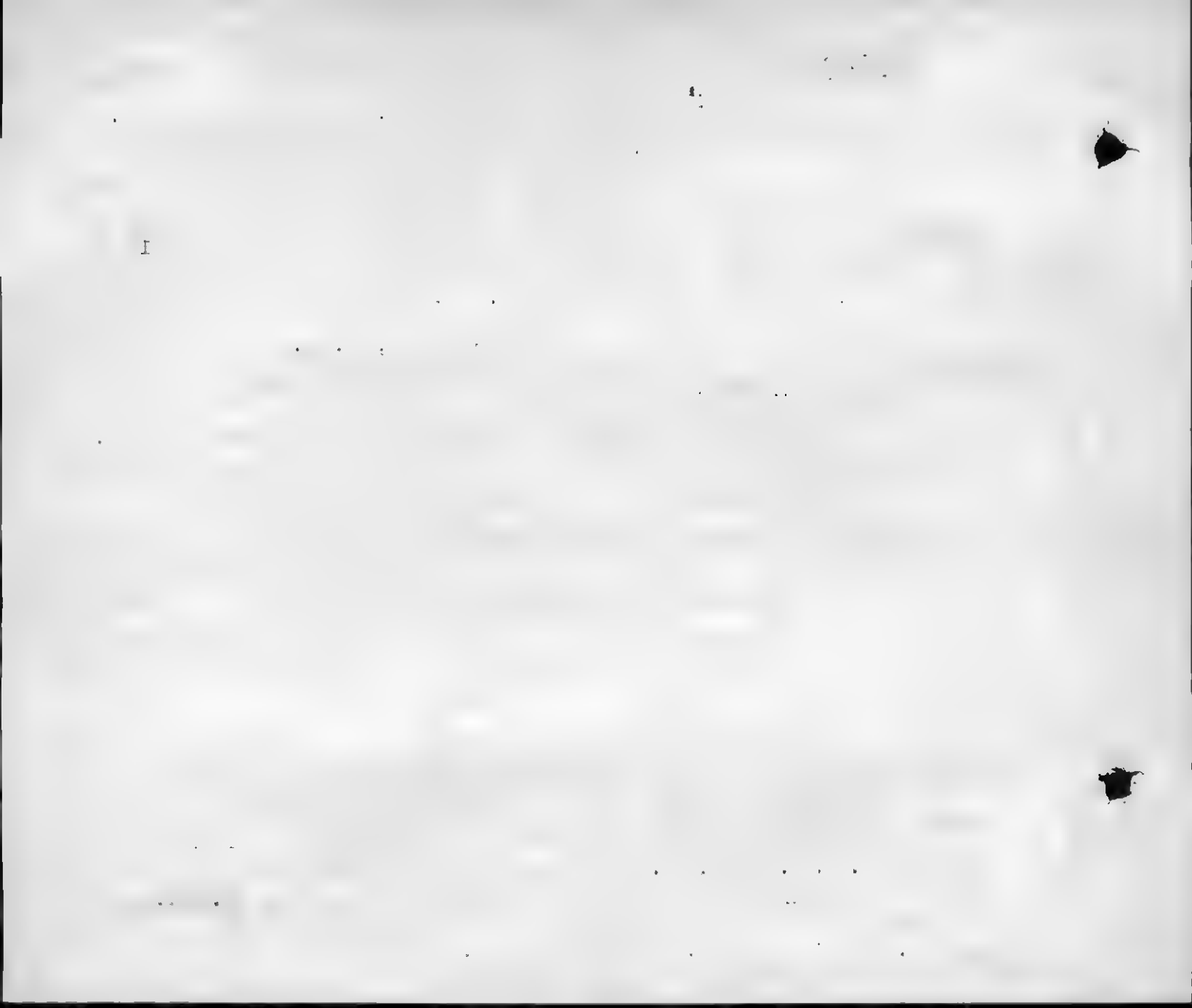
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02462 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02451

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Wash.	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN It 1948		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 807 Interval Road		d. STREET ADDRESS 807 Interval Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel Joseph Simmons		4. DATE OF DEATH Month Feb. Day 21 Year 1962			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 16, 1894		9. AGE (In years last birthday) 68		10. IF UNDER 1 YEAR Months 1 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) miner		10b. KIND OF BUSINESS OR INDUSTRY mines		11. BIRTHPLACE (State or foreign country) Accident, W.Va.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George Simmons		14. MOTHER'S MAIDEN NAME Lucinda Aronhalt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 232-03-2243		17. INFORMANT Address Clarence Simmons, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture Of Left Ventricle With Hemopericardium DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction Left Ventricle Anterior DUE TO Recent Recent (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a		INTERVAL BETWEEN ONSET AND DEATH Recent		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Accident, W. Va.	
20f. (City or town) Accident, W. Va.		20g. (County) Accident, W. Va.		20h. (State) Accident, W. Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-22-62	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Accident, W. Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-24-62		22c. NAME OF CEMETERY OR CREMATORY Accident Cemetery	
22d. LOCATION (City, town, or country) Accident, W. Va.		22e. (State) Accident, W. Va.		22f. (County) Accident, W. Va.	
23. FUNERAL DIRECTOR Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS Accident, W. Va.		24a. REC'D BY REGISTRAR FEB 26 1962	
24b. REGISTRAR'S SIGNATURE Clarence A. Funn					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

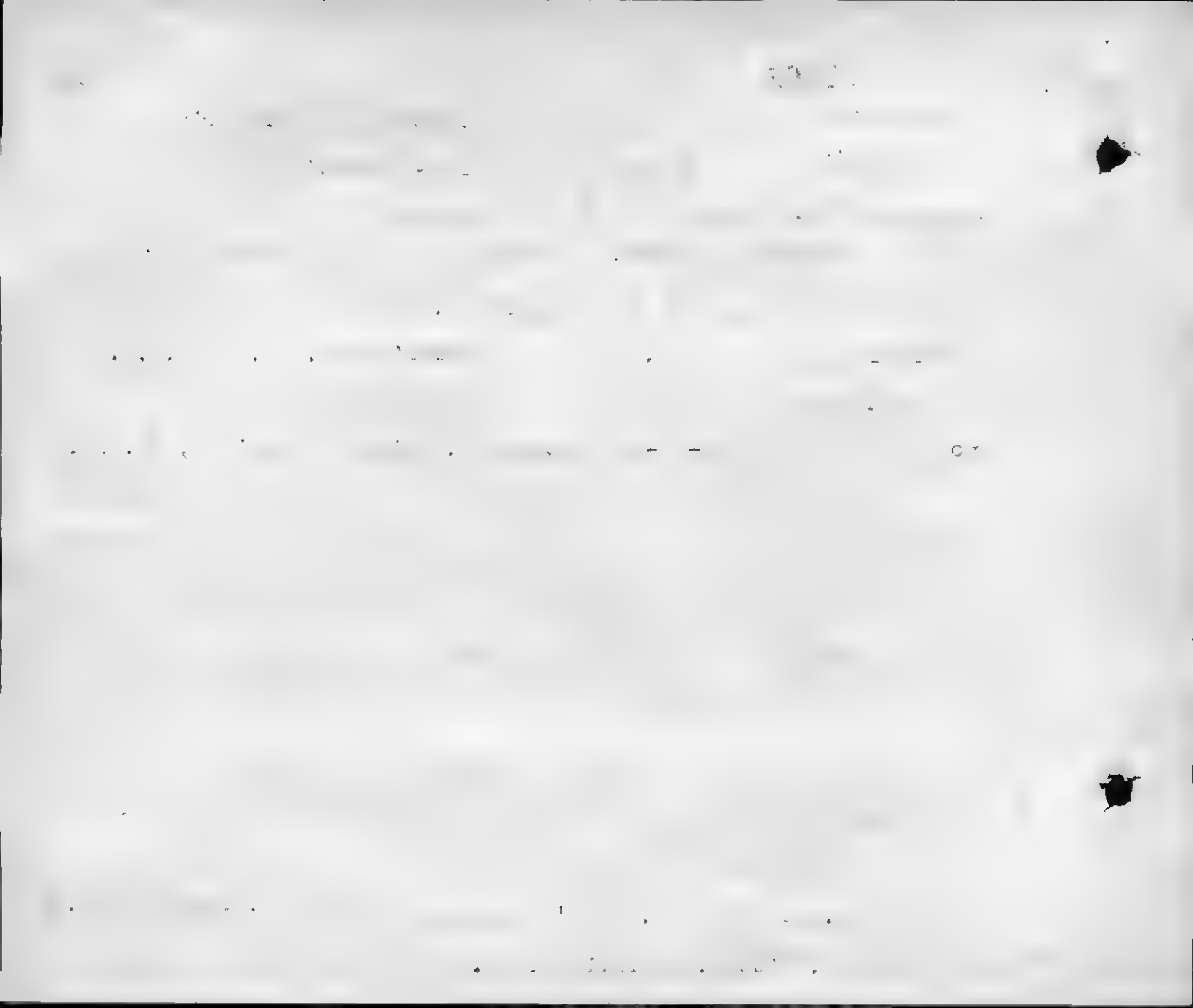
CERTIFICATE OF DEATH

02463

02463

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Rural-Myersville d. STREET ADDRESS Route # 2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) THOMAS KELLER SMITH First Middle Last		4. DATE OF DEATH Month February Day 23 Year 1962						
5. SEX male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1877 9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY own gen. farm		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Josiah Smith		14. MOTHER'S MAIDEN NAME Ellen Fox						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 219-36-2635 17. INFORMANT Gorman J. Smith, Myersville, Md. Rt. #2 Address _____						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.0 DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ causing the underlying cause last. DUE TO _____ (c) _____ </td> <td rowspan="2" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs </td> </tr> <tr> <td colspan="2"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ </td> </tr> </table>				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.0 DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ causing the underlying cause last. DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.0 DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ causing the underlying cause last. DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____						
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____						
21. I certify that (I) (this hospital) attended the deceased from 10:00 a.m. 1962 to 10:00 a.m. 1962 , that (I) (we) last saw the deceased alive on 1962 , and that death occurred at 10:00 a.m. , from the causes and on the date stated above.								
22a. SIGNATURE Charles F. Hess M.D.		22b. DATE SIGNED Feb 27 '62						
22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.		22d. ADDRESS Myersville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Feb. 26, 1962		23b. DATE THEREOF _____						
23c. NAME OF CEMETERY OR CREMATORY St. Mark's Lutheran		23d. LOCATION (City, town or county) Wolfsville, Frederick Co. Md (State) _____						
24. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		25a. REC'D BY REGISTRAR DATE FEB 27 '62						
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS _____						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

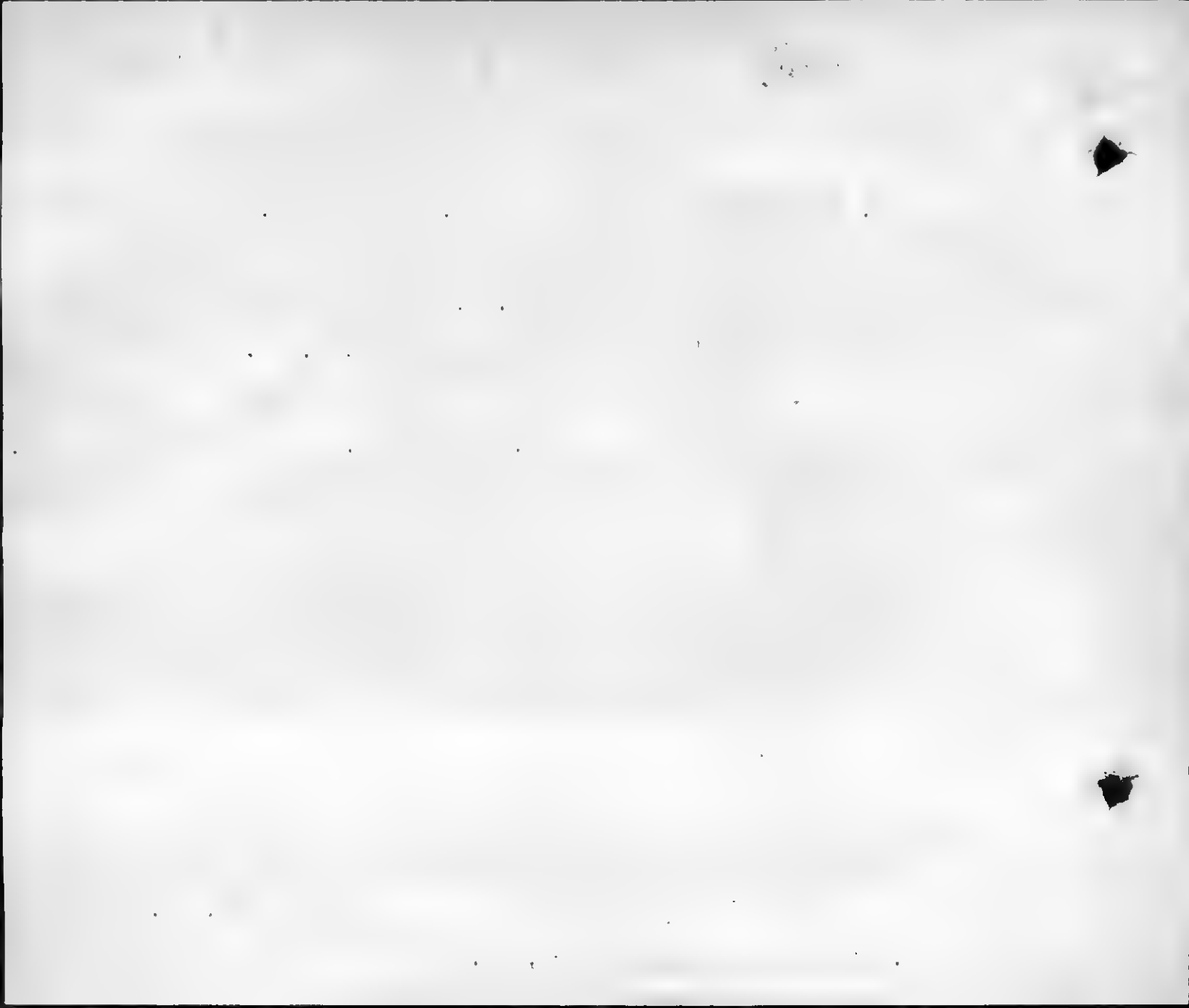
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02464

02453

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 18 W. Wilson Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTIE MILDRED SMOUSE First Middle Last 4. DATE OF DEATH FEB. 15 1962 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 4, 1879 9. AGE (In years last birthday) 82 yrs Months Days IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Mem's Clothing 11. BIRTHPLACE (County & State, or foreign country) Rowlesburg, W. Va. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel N. Shaffer		14. MOTHER'S MAIDEN NAME Nancy Pugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Florence A. Stouffer Glen Echo, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF URINARY BLADDER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS - HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 4 YEARS 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 2-16-1959 to 2-15-1962 , that (I) (the hospital) last saw the deceased alive on 2-15-1962 , and that death occurred at 11 A.M. from the causes and on the date stated above			
22a. SIGNATURE Antonio U. Pallagrosi M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22d. ADDRESS 1500 Pa Ave Hagerstown Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-62	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown, Md. ADDRESS		25a. REC'D BY REGISTRAR FEB 19 1962 25b. REGISTRAR'S SIGNATURE Carroll & P. 1962	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

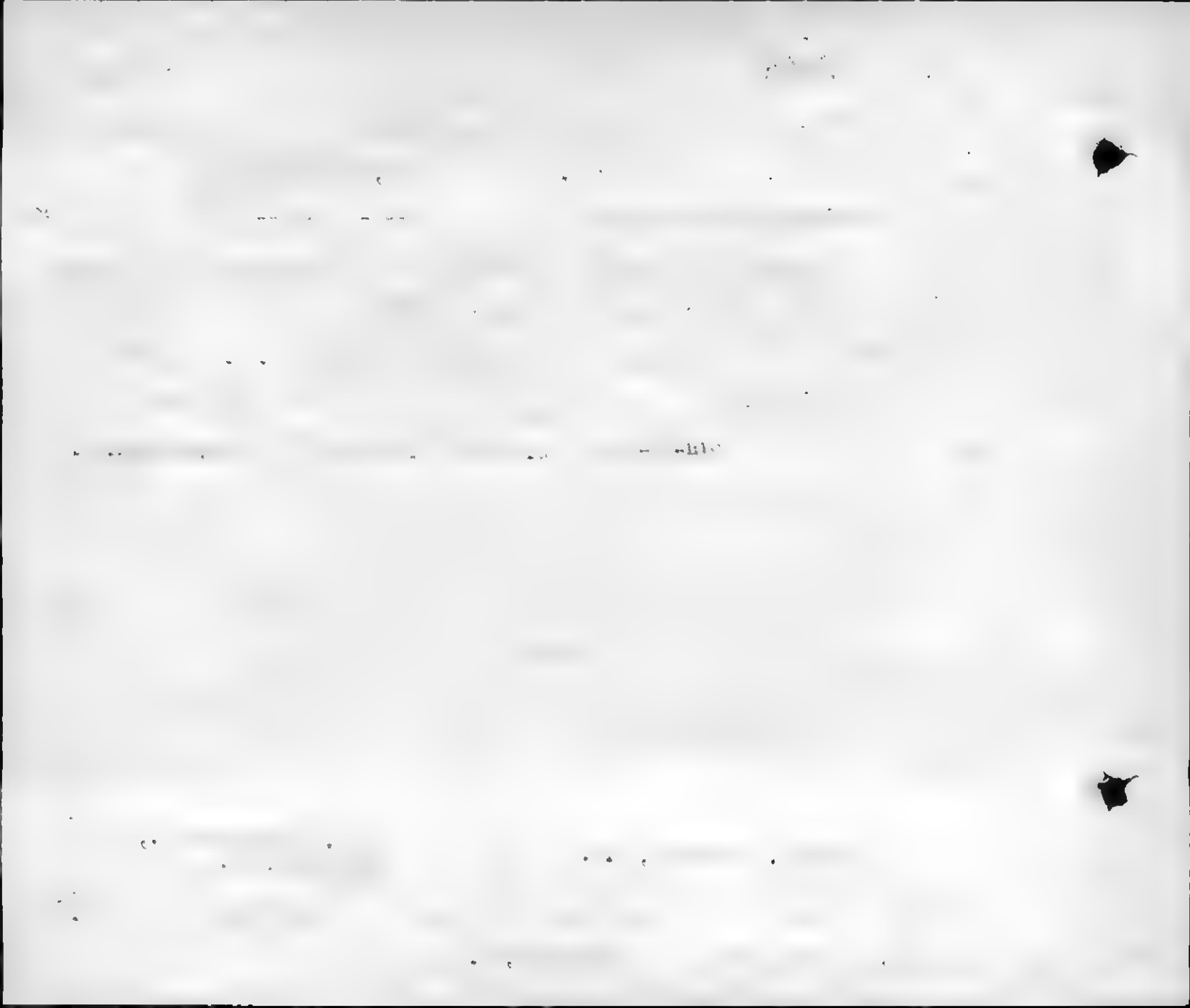
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02465

02154

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Hagerstown R # 5</u>	
c. LENGTH OF STAY IN IL <u>70 yrs.</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Edward</u> Last <u>Snook</u>		4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 26, 1878</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. UNDER 1 YEAR <u>6</u> Months <u>19</u> Days <u>62</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Lewistown, Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Maurice Snook</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ellen Mott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-2479</u>	
17. INFORMANT <u>Mrs. Charles R. Decker R # 5 Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Conjunctival abscess of r. kidney</u> Conditions, if any, which gave rise to immediate cause (b) <u>Nephrosclerosis, l. kidney</u> (c) <u>Removal of calculus from pelvis of l. kidney</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-5-1961</u> to <u>2-6-1962</u> , that (I) (we) last saw the deceased alive on <u>2-6-1961</u> , and that death occurred at <u>154</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>John H. Hornbaker, M.D.</u>		22b. DATE SIGNED <u>2:7:62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>		22d. ADDRESS <u>154 W. Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Horst</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 13 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm. A. Horst</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02466

02455

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN It <u>12 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>142 FAIRGROUND AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JENNIE C SPIELMAN</u>		4. DATE OF DEATH <u>FEBRUARY - 2 - 1962</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 18, 1878</u>	
9. AGE (In years last birthday) <u>83</u> yrs. <u>2</u> Months <u>14</u> Days		10. IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEAR BOONSBORO WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM STORM</u>		14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ADEN P. SPIELMAN</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Cholecystitis, acute; Cataracts, bilateral; Senile dementia.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 21, 1961</u> to <u>1961</u> , death <u>January 31, 1961</u> , and that death occurred <u>2:15 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Robert F. Keadle</u>	
22b. DATE SIGNED <u>2-3-62</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert F. Keadle</u>	
22d. ADDRESS <u>Hagerstown, Md.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 4, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BEAVER CREEK WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 6 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>		25c. ADDRESS <u>BOONSBORO MD.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02467 02156

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY **Washington** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Hagerstown**
c. LENGTH OF STAY IN b **1 Day**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Washington County Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE **Maryland** b. COUNTY **Washington**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Hagerstown**
d. STREET ADDRESS **57 West Franklin St**

3. NAME OF **HARRY PATRICK SPRANKLE**
(Type or print) First Middle Last

4. DATE OF DEATH **Feb 6 1962**
Month Day Year

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **Feb 5 1962**
last birthday | Months | Days | Hours | Min
yrs **1**

9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS)
last birthday | Months | Days | Hours | Min
yrs **1**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10b. KIND OF BUSINESS OR INDUSTRY **--** 11. BIRTHPLACE Country & State **Hagerstown Wash Co Md.** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Harry Sprankle** 14. MOTHER'S MAIDEN NAME **Phyllis Long**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) **No** 16. SOCIAL SECURITY NO **None** 17. INFORMANT **Harry Sprankle 57 W. Franklin St Hagerstown Md.** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Erythroblastosis + atelectasis at birth**
770.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
Pulmonary Atelectasis

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ☐

20c. TIME OF INJURY Month, Day Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
Hour e.m. p.m. 19 While at work ☐ Not While at work ☐

21. I certify that (I) (this hospital) attended the deceased from **2/5** 1962, to **2/5** 1962, that (I) (we) last saw the deceased alive on **2/5** 1962 and that death occurred at **2/5** M, from the causes and on the date stated above.

22a. SIGNATURE **J. D. Done Jr.** M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED **2/6/62**

22c. PHYSICIAN'S NAME (Type) **Andrew K. Coffman** 22d. ADDRESS **Hagerstown Wash Co Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **3/6/62** 23c. NAME OF CEMETERY OR CREMATORY **Rose Hill Cemetery** 23d. LOCATION (City, town or county) (State) **Hagerstown Wash Co Md.**

24. FUNERAL DIRECTOR'S SIGNATURE **Andrew K. Coffman Hagerstown Md.** ADDRESS **Hagerstown Wash Co Md.** 25a. REC'D BY REGISTRAR **DATE FEB 8 '62** 25b. REGISTRAR'S SIGNATURE **William S. Thane**

2081271212

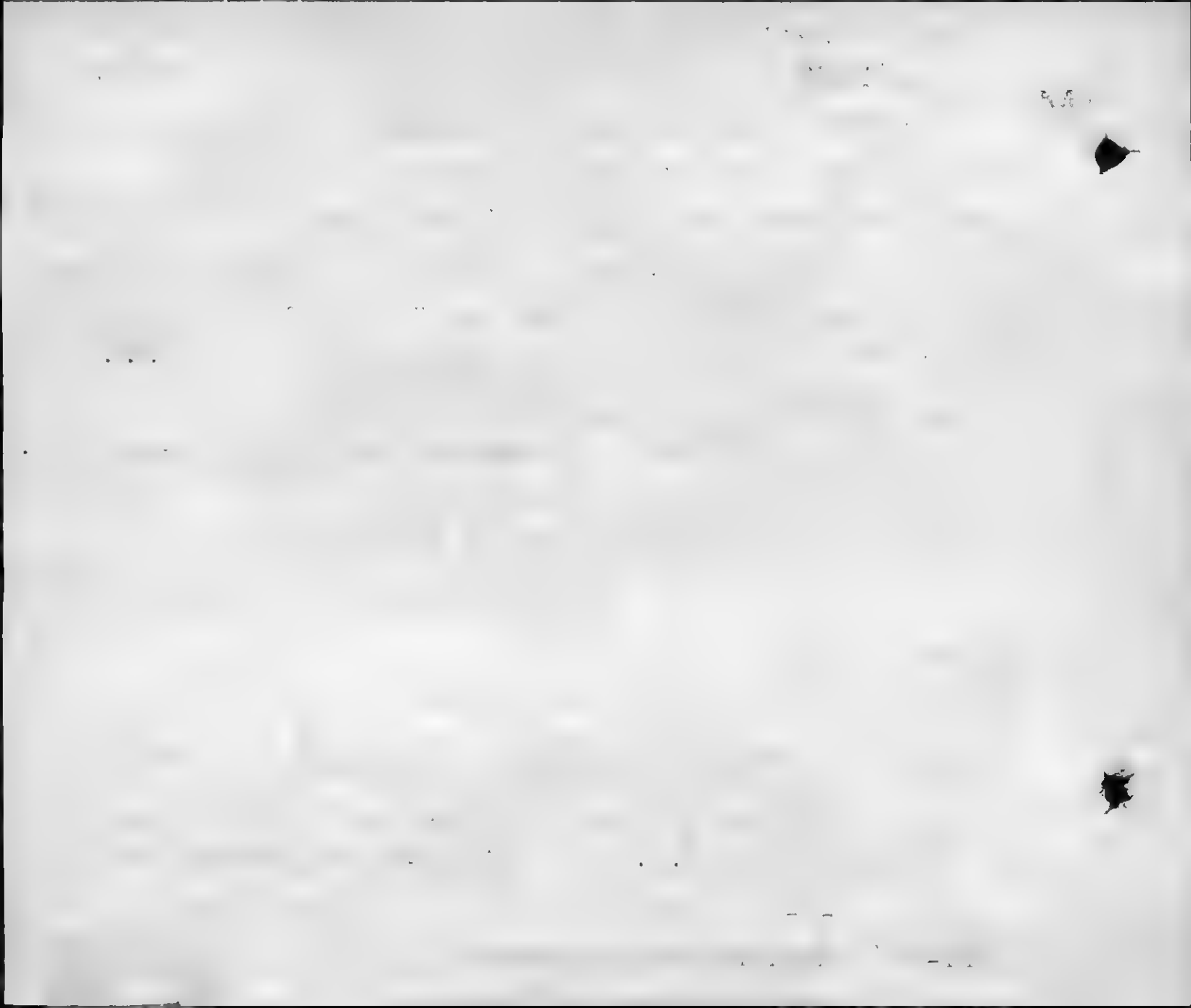


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																			
02468 1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN c. LENGTH OF STAY IN 1b 2 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GATEWAY CONVALESCENT HOME				02457 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 435 GEORGE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) ELLA NMN STANLEY First Middle Last				4. DATE OF DEATH FEBRUARY 13 1962 Month Day Year				9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Mins.											
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 18 1878		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) SHENANDOAH VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE				17. INFORMANT WASHINGTON COUNTY WELFARE BOARD HAGERSTOWN MD. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 4 - - - - - DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio Sclerosis (c) 10 yrs. DUE TO (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 3 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 1958 to Feb. 13, 1962 that (I) (we) last saw the deceased alive on Feb. 13, 1962 and that death occurred at 3:30 PM from the causes and on the date stated above.																			
22a. SIGNATURE David R. Brewer				22b. DATE SIGNED 2/16/62				22c. PHYSICIAN'S NAME (Type) DAVID R BREWER M. D.				22d. ADDRESS MAIN STREET CLEAR SPRING MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 2-16-62				23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY				23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND							
24. FUNERAL DIRECTOR'S SIGNATURE Charles M. Pinner				ADDRESS SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE William E. Pinner							
DATE FEB 19 '62																			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02469

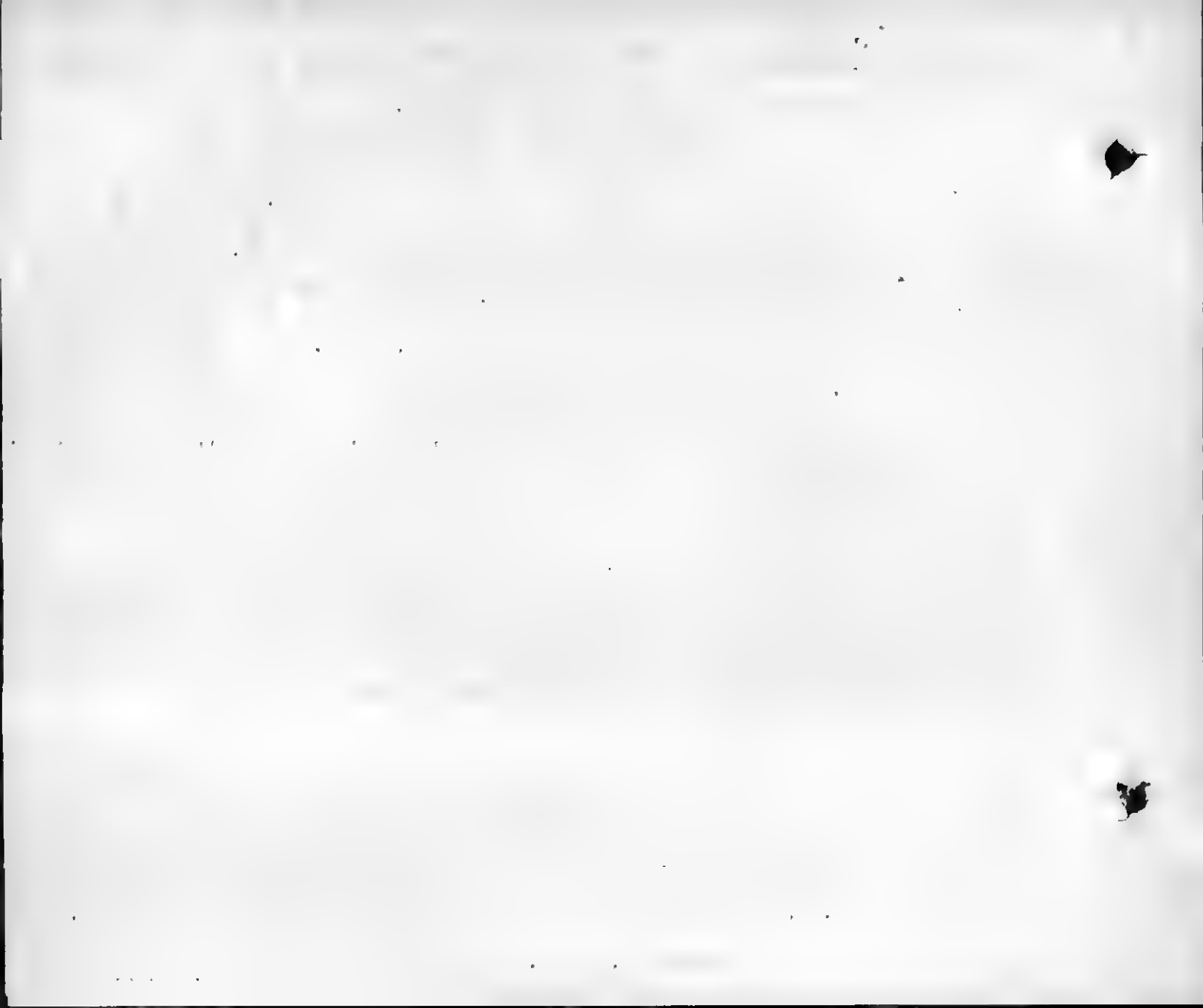
CERTIFICATE OF DEATH

Reg. Dist. No. 02158

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hagerstown		c. LENGTH OF STAY IN 1b 4 wks 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Avalon Manor		e. STREET ADDRESS 493 South Potomac St.	
3. NAME OF DECEASED (Type or print) EDITH First Middle LANDIS Stoner		4. DATE OF DEATH Month Feb. Day 17 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1879
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lancaster, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ezra F. Landis		14. MOTHER'S MAIDEN NAME Catherine Anthes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Paul Stoner, 493 S. Potomac St., Waynesboro, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 34X Chronic Brain Syndrome DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease; Calcification Mitral Valve			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-5-1962 to 2-17-1962 that I last saw the deceased alive on 2-17-1962, and that death occurred at 7 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Salmon M. Uhlty</i>		ADDRESS (Street, city or town, state) 998 Potomac Ave	
PHYSICIAN'S NAME (Type) <i>Salmon M. Uhlty</i>		DATE SIGNED 2-1-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 20, 1962	
22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) (State) Waynesboro Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Marlin Poe</i>		ADDRESS Waynesboro, Penna.	
24a. REC'D BY REGISTRAR DATE FEB 21 '62		24b. REGISTRAR'S SIGNATURE <i>L. S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 - be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

02470

02459

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN TB <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>386 N. PROSPECT ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL</u> <u>MILDRED</u> <u>STURTZ</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY</u> <u>26</u> <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/1908</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HAND SOWER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DRESS MFG. CO.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>STANLEY PALMER</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE ITNYEE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>714-09-4749</u>	
17. INFORMANT <u>FLVIN STURTZ</u>		Address <u>HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>General Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obesity</u> DUE TO (c) <u>Obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>			
19. WAS A AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Feb 26 1962</u> to <u>Feb 26 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb 26 1962</u> , and that death occurred at <u>7:30</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Beechley</u>		22b. DATE SIGNED <u>Feb 27 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. Beechley</u>		22d. ADDRESS <u>Hagerstown</u>	
23a. BURIAL, CREMATION REMOVAL <u>BURIAL</u>		23b. DATE THEREOF <u>2/28/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PINE HAVEN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. J. Norment</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 1 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>W. S. Turner</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 of 4 must be retained by the hospital or attending physician. Page 4 of 4 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

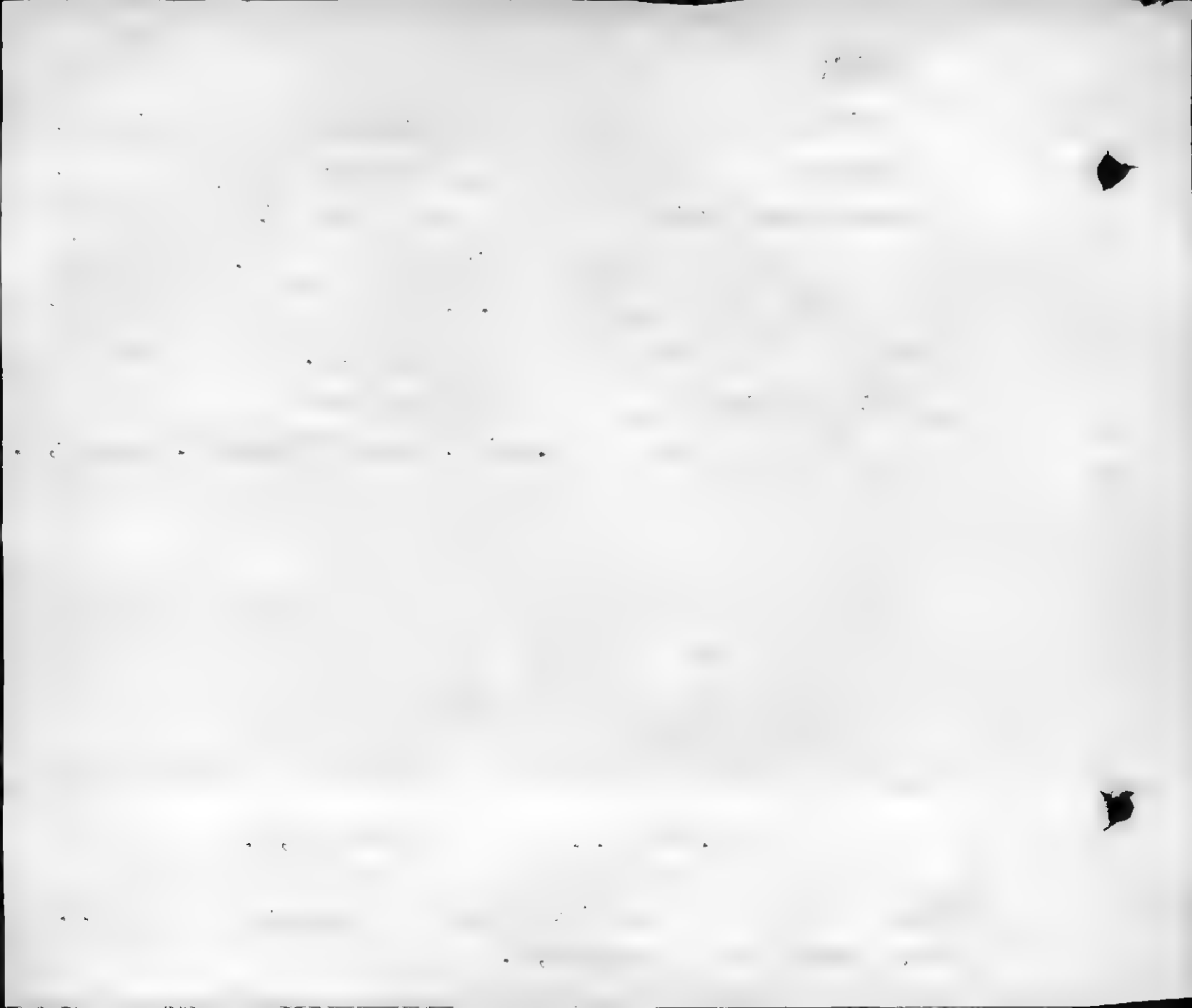
CERTIFICATE OF DEATH

02471

02460

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN TB <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>2219 Fairfax Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>John Louis Tiches</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>23</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1962</u>	9. AGE (In years last birthday) <u>5</u> yrs IF UNDER YEAR: Months <u>3</u> Days <u>5</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Louis James Tiches</u>			14. MOTHER'S MAIDEN NAME <u>Kathryn Franks</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Louis J. Tiches 2219 Fairfax Rd. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis, bilateral</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity + Immaturity</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>5 hr.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from <u>2/13</u> 1962 to <u>2/23</u> 1962 that (I) (we) last saw the deceased alive on <u>2/23</u> 1962 and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard A. Young M.D.</u>		22b. DATE SIGNED <u>2/24/62</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>			
22a. SIGNATURE <u>Richard A. Young M.D.</u>		22b. DATE SIGNED <u>2/24/62</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>			
23a. BURIAL, CREMATION <u>Burial</u> 23b. DATE THEREOF <u>2/26/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. S. Funn</u>			

100-111 Wm. G. Host



12
M
1
MEDICAL CERTIFICATION
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

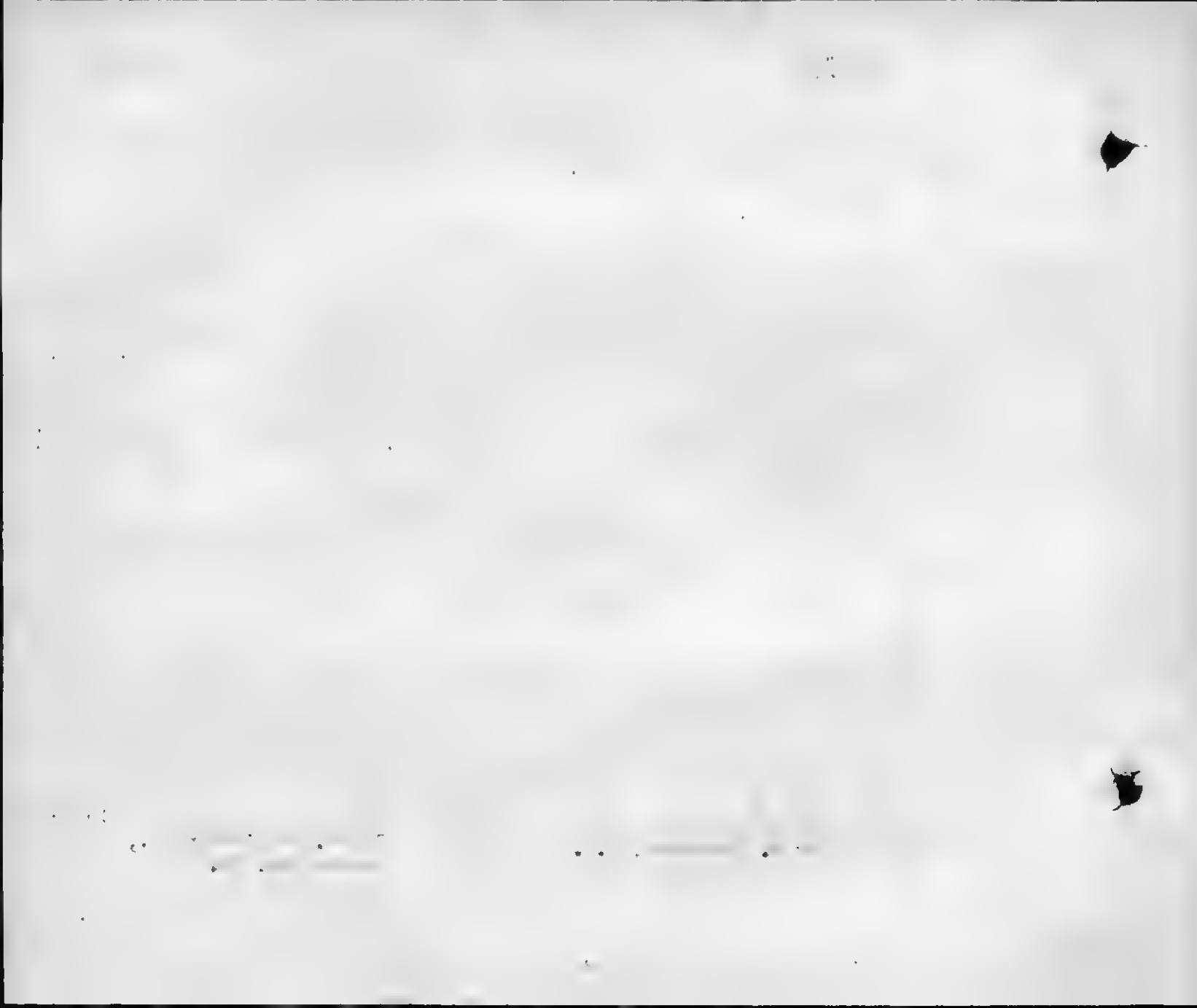
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02472

CERTIFICATE OF DEATH

02461

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>753 Guilford Ave.</u>		d. STREET ADDRESS <u>753 Guilford Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>BLAINE ALFRED TRIMMER</u>		4. DATE OF DEATH <u>February 28 1962</u>	
5. SEX <u>Male</u>		6. CO. OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 24, 1893 69 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild</u>	
13. FATHER'S NAME <u>Willis Trimmer</u>		14. MOTHER'S MAIDEN NAME <u>Bernice Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>173-03-3005</u>	
17. INFORMANT <u>Mrs. Fannie M. Trimmer</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction (probable)</u> Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardiovascular disease</u> (a), stating the underlying cause last, (c) <u>5 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-10-1941</u> to <u>2-28-1962</u> , that (I) (we) last saw the deceased alive on <u>12-22-1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Hornbaker</u>		22b. DATE SIGNED <u>2:28:62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>		22d. ADDRESS <u>154 W. Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/3/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem. Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Cofflan</u>		25a. REC'D BY REGISTRAR <u>5 '62</u>	
25b. REG. STRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02473

02463

(M)

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Antietam Furnace Lifetime

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Sharpsburg Md RFD #1

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

e. STATE Maryland

b. COUNTY

Washington

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Antietam Furnace

d. STREET ADDRESS

Sharpsburg Md RFD #1

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

Minnie

Florence

Tucker

Feb.

11

19 62

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

Aug. 18 1877

9. AGE (In years last birthday)

84 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (Country & State, or foreign country)

Antietam Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Jacob Boyer

14. MOTHER'S MAIDEN NAME

Annie (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address

Mrs. Alta Mae Reynolds Fairplay Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Acute right sided heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

Arteriosclerotic cardio-vascular disease

(c) DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)

INTERVAL BETWEEN ONSET AND DEATH
instant

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1961, to 2/11, 1962 that (I) (we) last saw the deceased alive on Feb. 2, 1962, and that death occurred at 6 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Walter H. Shealy M.D.

M.D.

22d. ADDRESS

22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

22f. (City or town)

(County)

22g. DATE SIGNED

2/12/62

Sharpsburg, Md.

23a. BURIAL, CREMATION REMOVAL (Specify)

Burial

23b. DATE THEREOF

Feb. 13-62

23c. NAME OF CEMETERY OR CREMATORY

Mt. View Cemetery

23d. LOCATION (City, town or county)

Sharpsburg Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

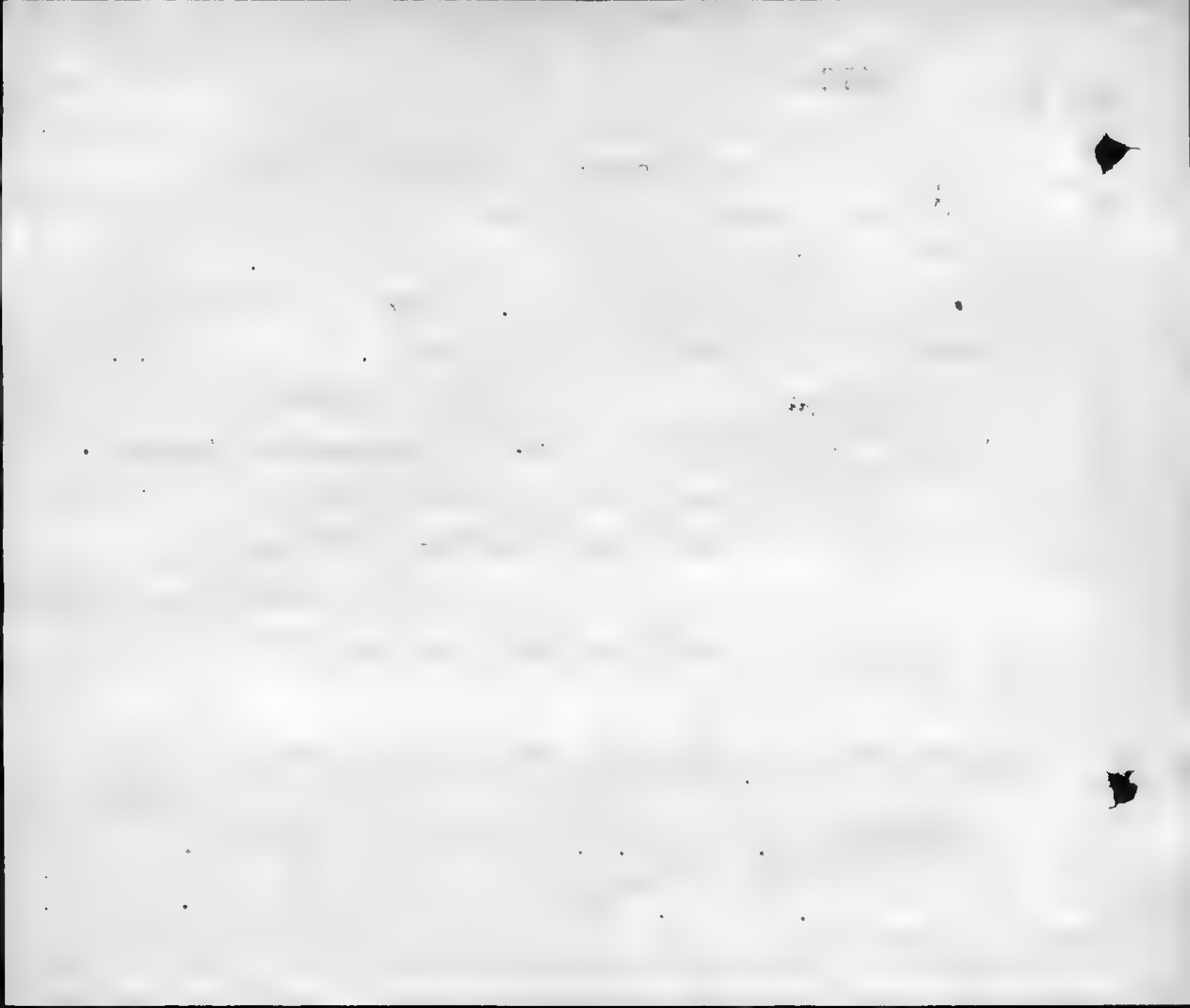
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE FEB 14 '62

C. H. & K. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

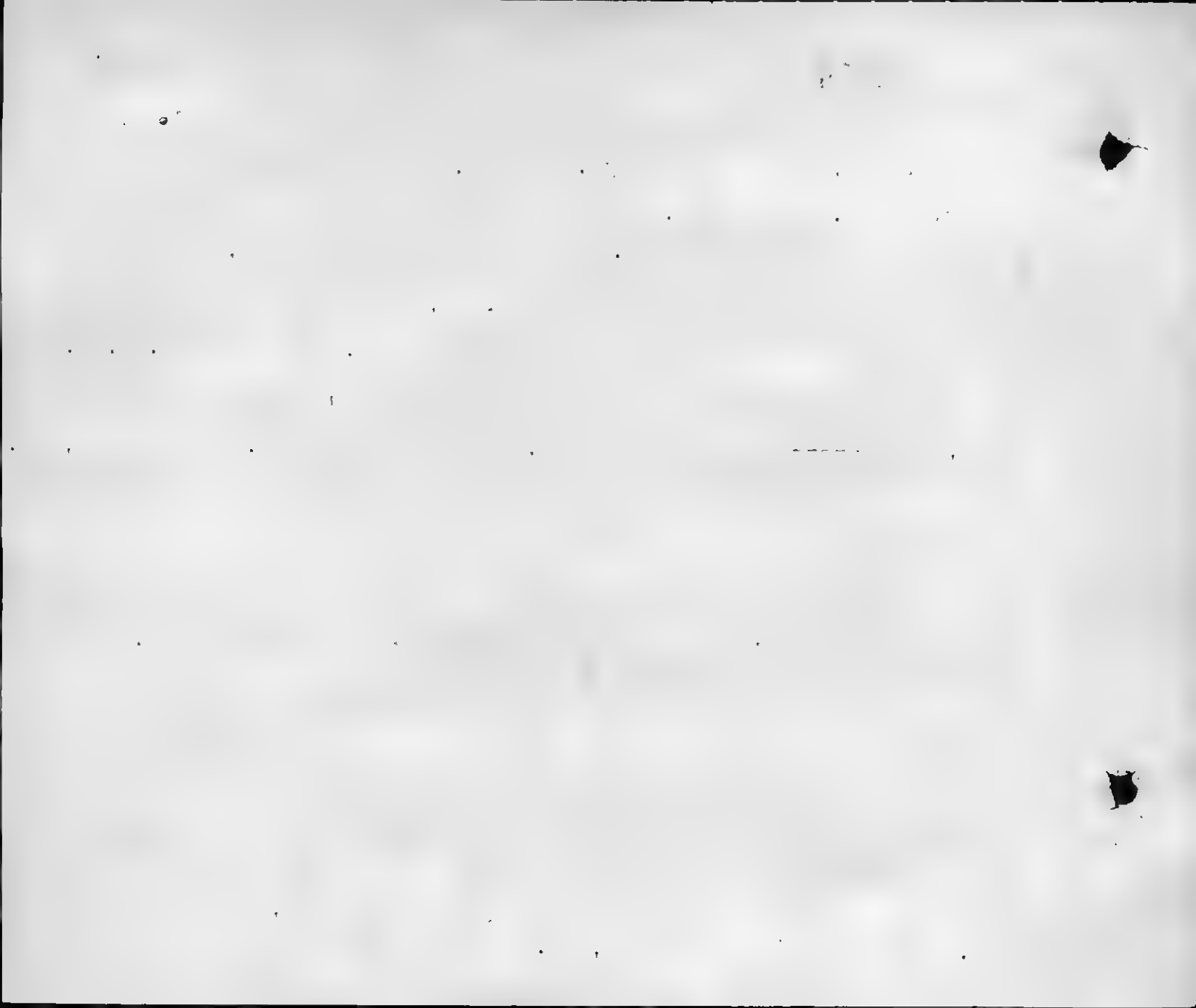
02474

02464

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown, c. LENGTH OF STAY IN (b) 21 dys. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rt. # 1 Oldtown d. STREET ADDRESS Sunny Flats	
3. NAME OF DECEASED (Type or print) First Ida Middle Mae Last Twigg		4. DATE OF DEATH Month Feb. Day 1 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1879	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 8 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Allegany Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Koontz		14. MOTHER'S MAIDEN NAME (Unknown) Skelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Myrtle Redinger		Address Rt. # 1 Oldtown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia, bilateral (b) Fracture of hip, right (c) 703.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). (1) Agranulocytosis. (2) General arteriosclerosis. (3) Nephrosclerosis. (4) Parkinsonism.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While walking in home fell fracturing hip	
20c. TIME OF INJURY Month, Day, Year 12-5-1961 Hour a.m. 12-5 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Home		20f. CITY OR TOWN Oldtown (County) Allegany (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>[Signature]</i> EXAMINER'S NAME (Type) Dr. E. W. Hitt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/62	
22c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery		22d. LOCATION (City, town, or country) (State) Oldtown, Maryland	
23. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.			
24a. REC'D BY REGISTRAR DATE 2/5/62		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

02475

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02165

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> c. LENGTH OF STAY IN 1b <u>5 MOS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GATEWAY CONVALESCENT HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>2523 PENNSYLVANIA AVENUE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES HENRY UNGER</u>		4. DATE OF DEATH <u>FEBRUARY 16 1962</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>JANUARY 6 1883</u>		9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u> 11. BIRTHPLACE (County & State, or foreign country) <u>FRANKLIN COUNTY PENNA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAM UNGER</u>		14. MOTHER'S MAIDEN NAME <u>MAY POPER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>220-26-5296A</u> 17. INFORMANT <u>MRS. HARLAN SCOTT HAGERSTOWN MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>3-4</u> IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> DUE TO (b) <u>Arterial Sclerosis</u> DUE TO (c) <u>Prostatic resection</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Prostatic resection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 14, 1961</u> to <u>Feb. 16, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb. 16, 1962</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>David R. Brewer</u>		22b. DATE SIGNED <u>2/20/62</u>		22c. PHYSICIAN'S NAME (Type) <u>DAVID R. BREWER M. D.</u>	
22d. ADDRESS <u>MAIN STREET CLEAR SPRING MARYLAND</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-19-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>	
23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MARYLAND</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles M. Kauer</u>		25a. REC'D BY REGISTRAR <u>FEB 20 1962</u>	
24b. ADDRESS <u>SUPER-BOUZER FUNERAL HOME HAGERSTOWN MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>Wm. L. Thoma</u>		25c. DATE <u>FEB 20 1962</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
02476																			
02166																			
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Downsville</u>					c. LENGTH OF STAY IN 1b <u>Hagerstown</u>														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Woburn Manor Boarding Home</u>					d. STREET ADDRESS <u>103 W. Franklin St.</u>														
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Martin</u> Last <u>Wagonhouser</u>					4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>19 62</u>														
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 15, 1873</u>		9. AGE (In years last birthday) <u>88</u> yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ice Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Waynesboro, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>214-09-2249</u>					17. INFORMANT Address <u>Mrs. Ethel Ralls 1710 Sherman Ave. Hagerstown, Md.</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. MYOCARDIA L IN FIBRATION</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) _____ INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)					20g. (County)					20h. (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>2/21/62</u> to <u>2/21/62</u> , that (I) (we) last saw the deceased alive on <u>2/21/62</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.										22a. SIGNATURE <u>Ralph F. Young</u> M.D.									
22c. PHYSICIAN'S NAME (Type) <u>Ralph F. Young M.D.</u>					22d. ADDRESS <u>101 E. Potomac St. Williamsport, Md.</u>					22b. DATE SIGNED <u>2/23/62</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>2/24/62</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>									
23d. LOCATION (City, town or county) <u>Hagerstown</u>					23e. (State) <u>Md.</u>					24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> <u>Wm. A. Horst</u>									
25a. REC'D BY REGISTRAR <u>DATE FEB 26 '62</u>					25b. REGISTRAR'S SIGNATURE <u>William S. Hanna</u>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

<div>1</div> <div>M.</div> <div>1</div>											
<div>02477</div> <div>02467</div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>WASHINGTON</div> <div>MARYLAND</div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>RURAL HAGERSTOWN</div> <div>c. LENGTH OF STAY IN 1b</div> <div>15 YEARS</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>ROUTE # 6 HAGERSTOWN MARYLAND</div>											
<div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div> <div>MARYLAND</div> <div>b. COUNTY</div> <div>WASHINGTON</div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>RURAL HAGERSTOWN</div> <div>d. STREET ADDRESS</div> <div>ROUTE # 6 HAGERSTOWN MARYLAND</div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>											
<div>3. NAME OF DECEASED (Type or print)</div> <div>ELIZABETH BESSIE WALLICK</div> <div>4. DATE OF DEATH</div> <div>FEBRUARY 15 19 62</div>											
<div>5. SEX</div> <div>FEMALE</div> <div>6. COLOR OR RACE</div> <div>WHITE</div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div> <div>8. DATE OF BIRTH</div> <div>SEPTEMBER 1 1879</div> <div>9. AGE (In years last birthday)</div> <div>82 yrs.</div> <div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>HOMEMAKER</div> <div>11. BIRTHPLACE (County & State, or foreign country)</div> <div>WASHINGTON COUNTY MD</div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>											
<div>13. FATHER'S NAME</div> <div>MONROE ZIMMERMAN</div> <div>14. MOTHER'S MAIDEN NAME</div> <div>LEAH BITNER</div>											
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)</div> <div>NO</div> <div>16. SOCIAL SECURITY NO.</div> <div>NONE</div> <div>17. INFORMANT</div> <div>MRS. RUTH GREEN</div> <div>Address</div> <div>ROUTE #6 HAGERSTOWN MD</div>											
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <u>Hemia</u></div> <div>DUETO (b) <u>Arteriosclerosis</u></div> <div>DUETO (c) <u>—</u></div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div><u>2 weeks</u></div> <div><u>years</u></div>											
<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>											
<div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div>											
<div>21. I certify that (I) (this hospital) attended the deceased from <u>14 Feb</u> to <u>15 Feb</u>, 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>14 Feb</u>, 19<u>62</u>, and that death occurred at <u>3:50 PM</u>, from the causes and on the date stated above.</div>											
<div>22a. SIGNATURE</div> <div><u>D Wilson</u></div> <div>M.D.</div> <div>ATTENDING PHYS.</div> <div><input type="checkbox"/></div> <div>MED. DIRECTOR</div> <div><input type="checkbox"/></div> <div>STAFF PHYS.</div> <div><input type="checkbox"/></div> <div>22b. DATE SIGNED</div> <div>22c. PHYSICIAN'S NAME (Type)</div> <div>D WILSON M. D.</div> <div>22d. ADDRESS</div> <div>135 N. POTOMAC ST HAGERSTOWN MARYLAND</div>											
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>BURIAL</div> <div>23b. DATE THEREOF</div> <div>2-17-62</div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>ROSE HILL CEMETERY</div> <div>23d. LOCATION (City, town or county)</div> <div>HAGERSTOWN MARYLAND</div> <div>(State)</div>											
<div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div><u>Charles Rouzer</u></div> <div>ADDRESS</div> <div>SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND</div> <div>25a. REC'D BY REGISTRAR</div> <div>DATE FEB 19 '62</div> <div>25b. REGISTRAR'S SIGNATURE</div> <div><u>Arthur E. Kenna</u></div>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

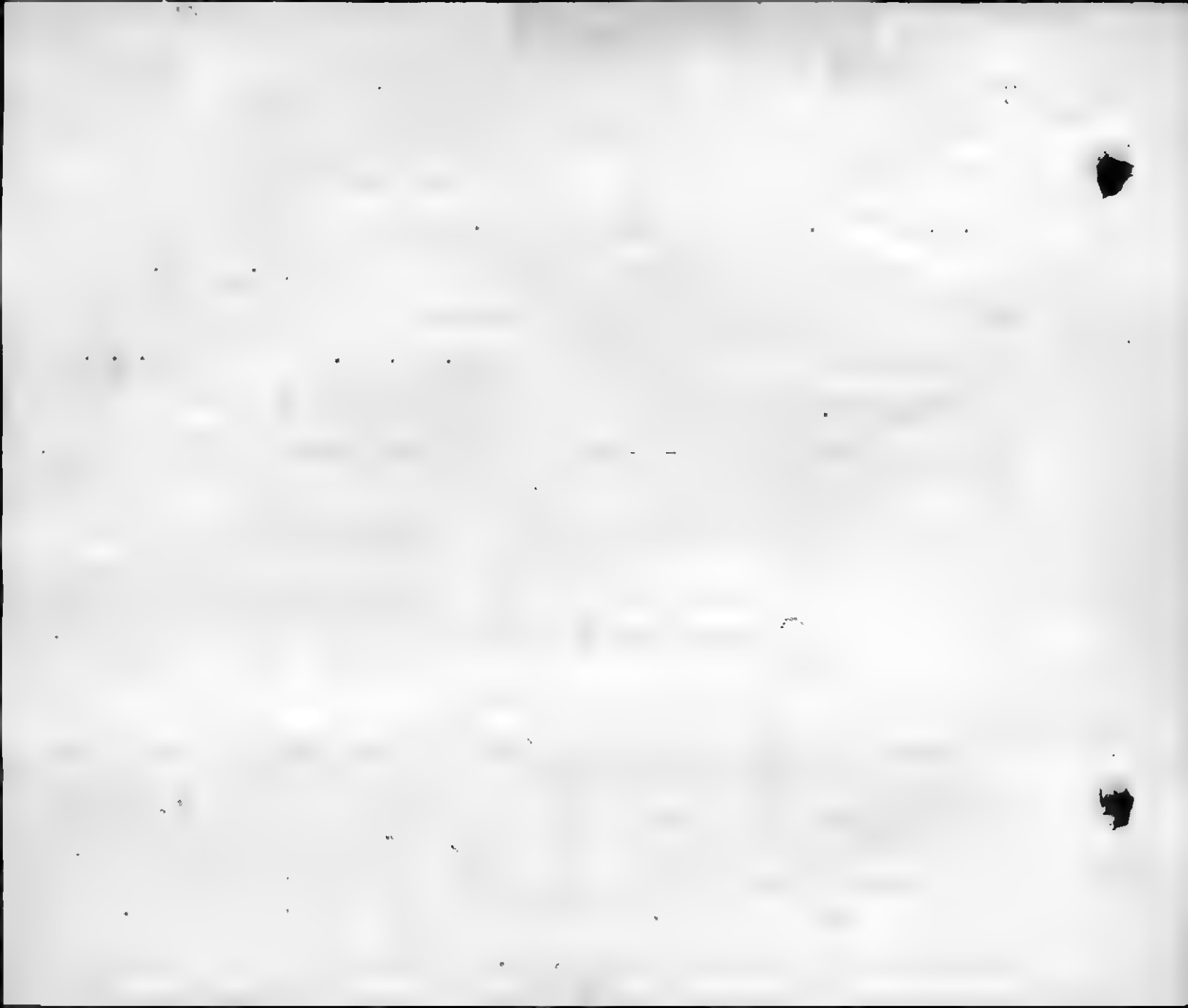
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02478

CERTIFICATE OF DEATH

02468

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CLEAR SPRING c. LENGTH OF STAY IN life LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) S. MARTIN ST.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CLEAR SPRING d. STREET ADDRESS S. MARTIN e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA MARIE WARNER		4. DATE OF DEATH Month Day Year FEB. 4, 19 62	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/5/1886	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days 9 10	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME DUTIES		12. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	
13. BIRTHPLACE (County & State, or foreign country) WASH. CO. MD.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME FREDERICK G. WARNER		16. MOTHER'S MAIDEN NAME ROSA FELLINGER	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		18. SOCIAL SECURITY NO. 212-38-9606	
19. INFORMANT JOSEPHINE HIGGINS		Address CLEAR SPRING, MD.	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Premia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of bladder, urinary (c) 1 year		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arterio sclerosis		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO		22b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
23a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23d. (City or town) (County) (State)	
24. I certify that (I) (this hospital) attended the deceased from Oct 30, 1961 to Jan 25, 1962 , that (I) (we) last saw the deceased alive on Jan 25, 1962 , and that death occurred at 11:58 A.M. from the causes and on the date stated above.		25. SIGNATURE Joseph G. Crisp M.D. 26. ADDRESS 115 King St. Hagerstown Md.	
27a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		27b. DATE THEREOF 2/7/62	
28a. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY		28b. LOCATION (City, town or county) (State) CLEAR SPRING, MD.	
29a. FUNERAL DIRECTOR'S SIGNATURE Margaret K. Rowland		29b. CLEAR SPRING, MD. DATE FEB 8 '62	
30a. REC'D BY REGISTRAR Crisp		30b. REGISTRAR'S SIGNATURE Crisp	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02479

02469

PLACE OF DEATH
a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

c. LENGTH OF STAY IN lb

3 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WASH. CO. HOSPITAL

3. NAME OF DECEASED
(Type or print)

ANDEA

LYN

WILES

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

FEBRUARY 21-1962

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

13. FATHER'S NAME

WILLIAM WILES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

MAXINE VIRGINIA SHANK

WILLIAM WILES

242 S. MULBERRY ST.

HAGERSTOWN MD (FATHER)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

754.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work
Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 19, from the causes and on the date stated above.

22a. SIGNATURE

Charles E. Hess

22c. PHYSICIAN'S NAME (Type)

MD

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

FEB 26 1962

23c. NAME OF CEMETERY OR CREMATORY

BEAVER CREEK CEMETERY

23d. LOCATION (City, town or county)

BEAVER CREEK WASH. CO. MD

24. FUNERAL DIRECTOR'S SIGNATURE

John H. Best

ADDRESS

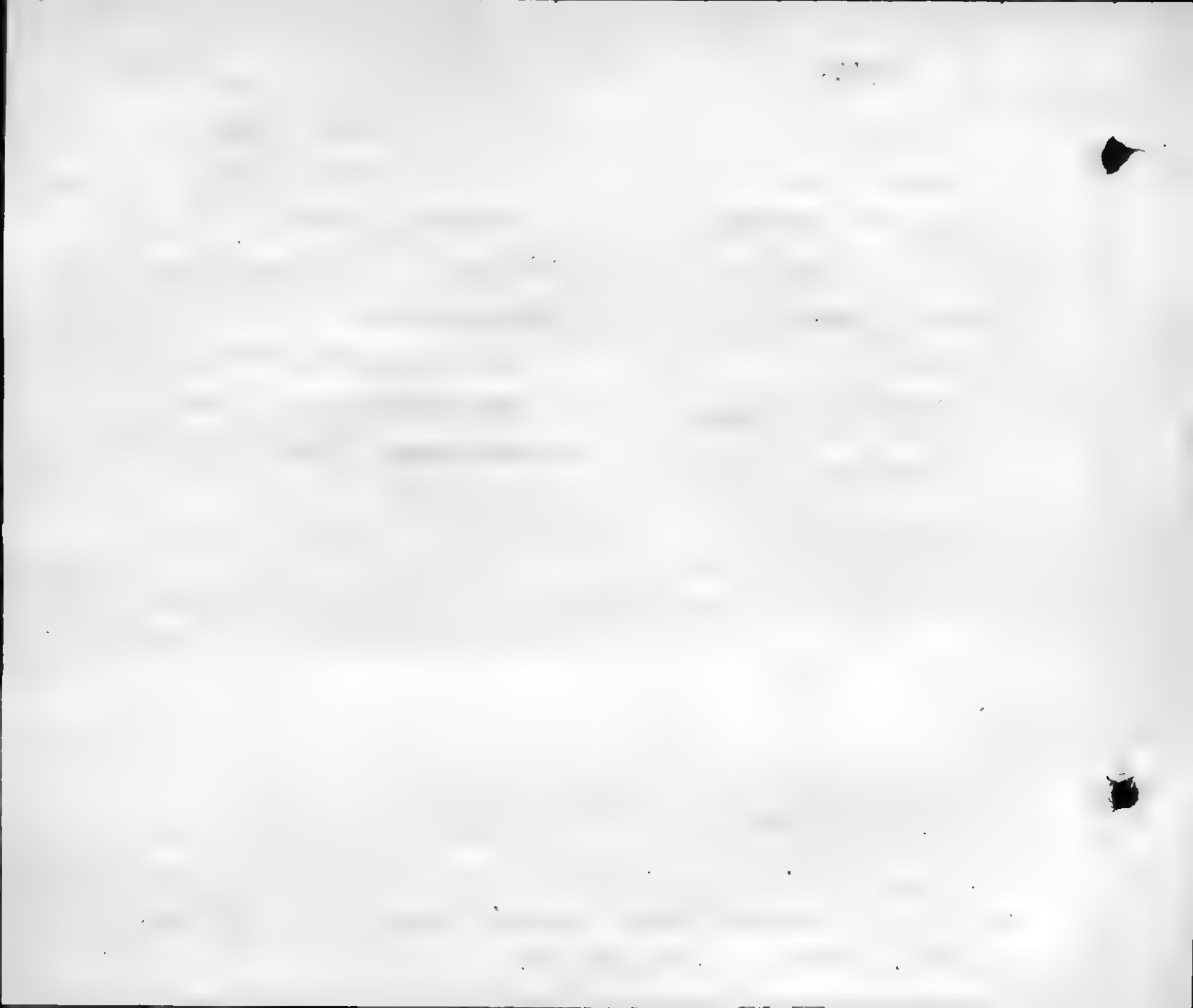
BOONSBORO MD

25a. REC'D BY REGISTRAR

DATE FEB 28 '62

25b. REGISTRAR'S SIGNATURE

Charles E. Hess



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02470

02480

1. PLACE OF DEATH
a. COUNTY WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN b. 11 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1316 SALEM AVENUE

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE MARYLAND b. COUNTY WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
d. STREET ADDRESS 1316 SALEM AVENUE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) VERA JEAN WISHARD
4. DATE OF DEATH FEBRUARY 18 19 62
5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH JANUARY 19 1928
9. AGE (In years, if UNDER 1 YEAR, last birthday) 34 yrs Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS 10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT 11. BIRTHPLACE (State or foreign country) BIG SPRINGS MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HERBERT McALLISTER 14. MOTHER'S MAIDEN NAME LIDA SHANK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 215-26-8452 17. INFORMANT FRED H WISHARD HAGERSTOWN MARYLAND
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) gun shot Wound penetrating entire Head
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None on leave from U.S. Postmaster
DUE TO (c)
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I/a
None on leave from U.S. Postmaster

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

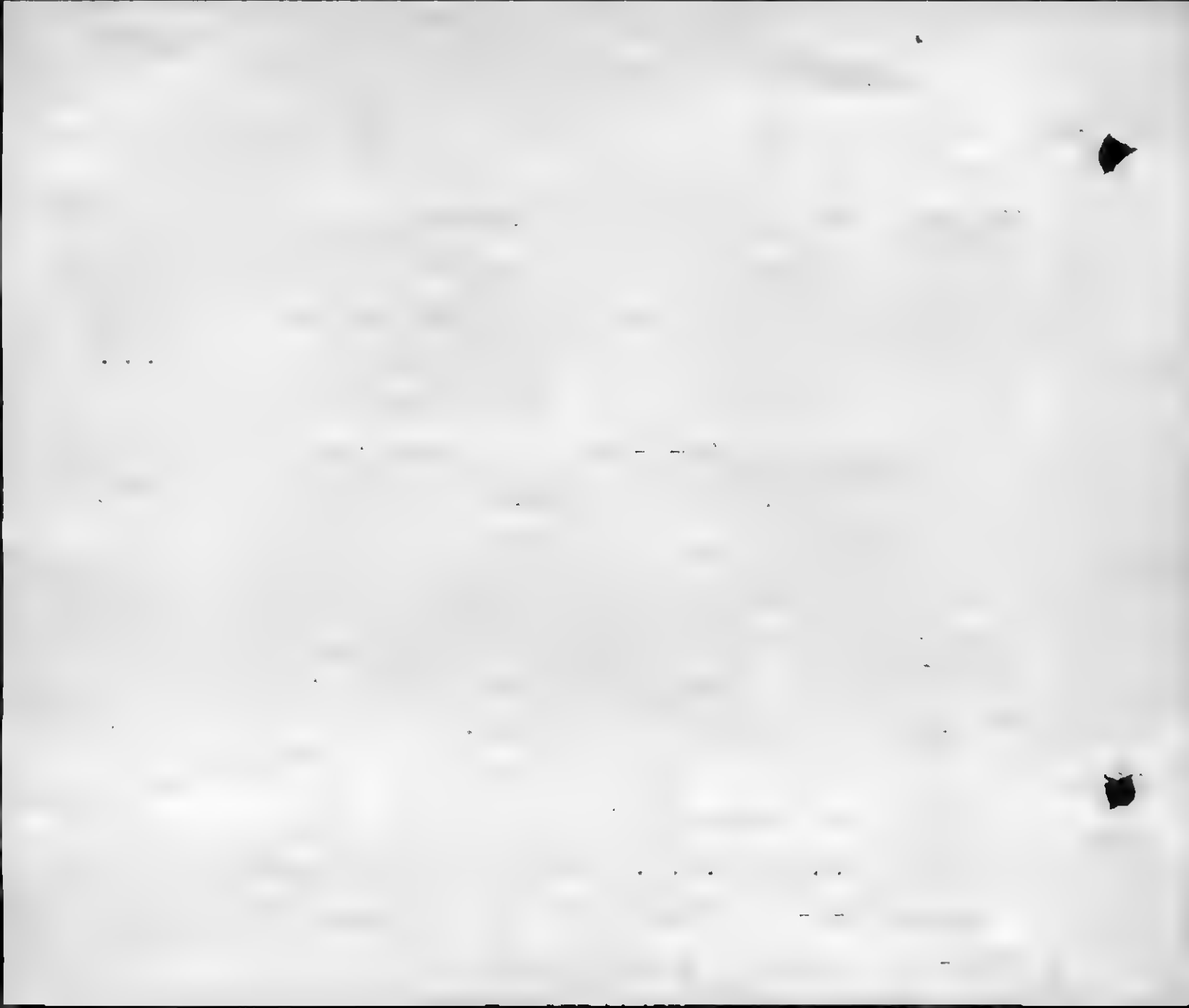
20a. EXTERNAL CAUSE WAS PRIMARY (a) CONTRIBUTING CAUSE OF DEATH. gun shot wound of head
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I/a of Item 18.)
20c. TIME OF INJURY Month, Day, Year 2-18-62 Hour a.m. 4
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home 20f. (City or town) Hagerstown (County) Washington (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE A. E. Dittor Jr. M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) E.W. DITTO JR., M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ 215 W WASHINGTON ST
Address (Street, city, town, or county) HAGERSTOWN MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 2-21-62 22c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEMORIAL GARDEN 22d. LOCATION (City, town, or country) HAGERSTOWN MARYLAND
23. FUNERAL DIRECTOR SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND ADDRESS

24a. REC'D BY REGISTRAR FEB 26 '62 24b. REGISTRAR'S SIGNATURE Carroll S. Thrane



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02481

1. PLACE OF DEATH a. COUNTY <u>02481</u> <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>125 N. Conococheague Street</u>		d. STREET ADDRESS <u>125 N. Conococheague St.</u>	
3. NAME OF DECEASED (Type or print) <u>David</u> <u>Walt</u> <u>Young</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>19 62</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Downsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah Young</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 18 2344</u>	
17. INFORMANT <u>Mr. Lester Young</u>		18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>HC, myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>intermittent</u> (c) <u>arrhythmia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Williamsport</u> County <u>Maryland</u> (State)	
21 I certify that (I) (th's hospital) attended the deceased from <u>2/22/62</u> to <u>2/24/62</u> , that (I) (we) last saw the deceased alive on <u>2/22/62</u> , and that death occurred at <u>11</u> M, from the cause and on the date stated above.			
22a. SIGNATURE <u>Robert Young</u>		22b. DATE SIGNED <u>2/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert Young</u>		22d. ADDRESS <u>Williamsport, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 25 -62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery.</u>		23d. LOCATION (City, town or county) <u>Williamsport</u> (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Williamsport, Md</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>C. L. Thomas</u>			

David

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02472

02482

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Yr		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 1004 Linwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) ANNA CARCE ZIMMERMAN		4. DATE OF DEATH Month FEB.		Day 8		Year 1962		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30 1873		9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0		12. Hours 0		13. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Md. Frederick Frederick Co		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Calvin A. Rhodes		14. MOTHER'S MAIDEN NAME Susan C. Steiner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Elizabeth Bragunier		Address 1004 Linwood Rd Hagerstown Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of breast, rt., recurrent DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days 18 years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (was) attended the deceased from 2-27- , 1961, to 2-8- , 1962 that (I) (was) last saw the deceased alive on 2-8- , 1962, and that death occurred at 9 P.M. , from the causes and on the date stated above.		22a. SIGNATURE Victor L. Ramos, M.D.		22b. ADDRESS Western Md. State Hospital Hagerstown, Md.		22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		22d. DATE SIGNED Feb. 9, 1962		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. DATE SIGNED Feb. 9, 1962		22g. SIGNATURE Arthur S. Ramos		22h. ADDRESS Western Md. State Hospital Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/62		23c. NAME OF CEMETERY OR CREMATORY Mt Hope Cemetery		23d. LOCATION (City, town or county) Woodsboro Fred Co Md		23e. (State) Md		24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24a. ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR FEB 13 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Ramos									

52250

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02483

02473

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 7 weeks			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Martin Manor Rest Home				e. STREET ADDRESS 445 Edgewood Drive			
3. NAME OF DECEASED (Type or print) Edward Bomberger Zimmerman				4. DATE OF DEATH Month February Day 11 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1869	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man
10b. KIND OF BUSINESS OR INDUSTRY St. Roads Com.			11. BIRTHPLACE (County & State, or foreign country) Near Williamsport, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward R. Zimmerman				14. MOTHER'S MAIDEN NAME Catherine Bomberger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No				16. SOCIAL SECURITY NO. 213-24-9229			
17. INFORMANT Mrs. Emma T. Zimmerman				Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH 3 years
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 42 0.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostatic Hypertrophy							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Hagerstown	20g. (County) Washington	20h. (State) Md.		
21. I certify that (I) (this hospital) attended the deceased from June 5, 1958 to Feb. 11, 1962 ; that (I) (we) last saw the deceased alive on Feb. 8, 1962 , and that death occurred at 12:45 M. from the causes and on the date stated above.							
22a. SIGNATURE Paul Harrison				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb 11 1962	
22c. PHYSICIAN'S NAME (Type) Paul Harrison, M. D.				22d. ADDRESS 318 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-13-62	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown, Md.				25a. REC'D BY REGISTRAR FEB 15 '62		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Harrison

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